JUL 1 2 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING ____ B. WING ____	C 06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	PO BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to transfer 1 of 3 sampled residents (Resident #3), who experienced falls/fractures, as specified in a physician's order. Findings included: Resident #3 was admitted to the facility on 02/20/13 and readmitted on 03/12/13. The resident's diagnoses included history of deep venous thrombosis, history of anticoagulant therapy, osteopenia, osteoporosis, and osteoarthritis. The resident's admission medications included Plavix (for anti-clotting) 75 milligrams (mg) daily (QD). A 02/21/13 falls risk assessment documented Resident #3 was at high risk for falls, scoring 18 (with a score of 10 or higher putting the resident at high risk). The resident was found to be at high risk due to intermittent confusion, experiencing 1 - 2 falls in the past 3 months, having poor vision, being chairbound, not being able to perform gait/balance, having 1 - 2 predisposing diseases/diagnoses, and taking 3 - 4 medications which increased fall risk.	F 323	Facility will audit completed for all residents c transfer orders & any open-ended or confusing orders were clarified per phone conversation c DON on 7/12/13 @ 3:06 PM [signature] Resident #3 transferred/admitted to Johnston Medical Center on June 22, 2013. All residents' physician's orders and care plans canvassed by committee composed of DON, Clinical DON, SDC, QA Coordinator, MDS Coordinator and facility's Physical Therapist to determine and comply with the following: physician's order is ascertained as one (1) method of transfer, the physician's order for transfer is documented/reflected in the care plan, and that the one (1) method of transfer is present in the "FYI" section of the facility's electronic charting system for Nursing Assistants' review and expected compliance. Safety, as the ultimate goal, will be the determining factor in assessing/establishing the one (1) method of transfer.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/10/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 On 02/21/2013 the resident was identified as being at risk for falls on her care plan due to her fall history, use of psychotropic medications, osteoarthritis, recent cerebrovascular accident, and fatigue and weakness. Interventions to this problem included transfer with the Golvo lift utilizing two staff members. A 02/22/13 physician order documented the resident was to be transferred using a Golvo lift with a 2-person assist. Resident #3's 02/27/13 Admission Minimum Data Set (MDS) documented the resident had short and long term memory impairment, was moderately impaired in decision making, required extensive assistance by two staff members for transfers, and was unsteady with surface to surface transfers, only being able to stabilize herself with staff assistance. A 03/05/13 physician's order sent the resident out to the emergency room (ER) due to left hip pain with the left lower leg being mottled and cool to the touch. Resident #3's 03/12/13 hospital Discharge Summary documented the discharge diagnosis was left lower extremity arterial thromboembolism. The family declined invasive procedures, and the resident was discharged back to the nursing home on Lovenox (anticoagulant) therapy. The resident was receiving 60 mg Lovenox twice daily (BID). A 03/12/13 physician's order continued the use of the Golvo lift and two-person assist for Resident	F 323	All methods of transfer will be validated by the physician's approval and signature and documented in the care plan. Licensed Nurses, exercising their nursing judgment and/or the Physical Therapist, through the evaluation process, will ensure that the residents be provided with the safest transfer method/device. Should discrepancies arise in opinions regarding the ordered method of transfer with /among family members, the facility will seek resolution with participating input of the physician, Social Worker, unit nurse, MDS Coordinator, Clinical DON and the Administrator. The Regional Ombudsman will be contacted for assistance if unable to resolve within the facility.	

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F 323	Continued From page 2 #3's transfers. A 03/19/13 falls risk assessment documented Resident #3 was at high risk for falls, scoring 18. A 03/26/13 physician order discontinued the use of the Golvo lift and initiated the use of the Sabina lift for the resident's transfers. The order documented the transfers could be completed with one or two staff members. The resident's care plan was also revised to reflect the resident's new transfer status. On 04/18/13 the physician ordered an x-ray of Resident #3's left foot secondary to swelling (4+ edema), pain, and bruising. The x-ray determined the resident had a fracture of her fifth and possibly fourth left distal metatarsals. A 04/20/13 physician's order decreased Resident #3's Lovenox to 40 mg BID. A 04/22/13 orthopaedic consult documented, "Left (symbol used) foot swelling dorsally, appears secondary to (symbols used) trauma, some erythema & (and) localized collection, suspect hematoma. Echymosis (bruising) of toes & dependent border of foot (much improved per family member)." The orthopaedist placed the resident on Doxycycline (antibiotic) 100 mg BID, and ordered touch down weight bearing (TDWB) only for all transfers. A 04/28/13 physician's order started Resident #3 on Omnicef (antibiotic) 300 mg BID x 10 days for continued swelling and redness in the left foot. A 06/06/13 orthopaedic consult documented	F 323	The SDC will conduct in-services for Nursing Assistants to include, but not limited to, the procedure for obtaining the physician ordered/care planned method of transfer as documented in the "FYI" section of their electronic charting system. This is to be checked every shift by the Nursing Assistant. Further instruction will include their complete adherence to the one (1) method of transfer as shown in the "FYI" section and instruction on how to correctly respond to family members requesting a different type of transfer be utilized. The Nursing Assistant is not to change the method of transfer and to report the request to their immediate supervisor for appropriate action. The SDC will include safe transfer education (physician order, care plan, "FYI" section of electronic charting and method of transfer performed should all be same) in her orientation for newly hired nursing employees, yearly evaluation (skills' lab) for nursing department members and to be included in the lesson plan for the facility's annual "Slips, Trips and Falls"	

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F 323	Continued From page 3 Resident #3's metatarsal fractures were clinically healed. He placed the resident on weigh bearing as tolerated (WBAT) for transfers. The resident's 06/06/13 Quarterly MDS documented her cognition was severely impaired, she required extensive assistance from two staff members for transfers, and when transferring from surface to surface and from a seated position to a standing position the resident was so unsteady that she required staff assistance to stabilize. A 06/06/13 falls risk assessment documented Resident #3 was at high risk for falls, scoring 20. This falls assessment identified the resident as being legally blind. An incident/accident report documented on 06/13/13 at 7:30 PM Resident #3's feet became entangled with her nursing assistant's (NA's) feet when the NA was attempting to transfer the resident alone from the chair to the bed using a gait belt. The resident was sent out to the ER because of complaints of pain (in the left chest and rib area). The resident suffered two one-inch skin tears to the left elbow and a three centimeter (cm) hematoma to the back of her head. A 06/14/13 nurse's note documented the resident returned from the hospital where it was determined she had fractures to her left sixth and seventh ribs. A 06/22/13 nurse's note documented Resident #3 was sent out to the ER due to respiratory problems and poor appetite and fluid intake.	F 323	in-service conducted in partnership with the Physical Therapy Department. The QA Coordinator, who serves as the Fall Committee Chair, will investigate any resident fall involving a transfer. She will designate on the Fall Investigation Report if the incorrect method of transfer was performed and if communication was clear regarding the type of transfer ordered. If not, she will refer report to the SDC for counseling and/or disciplinary action of involved staff members.	

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F 323	Continued From page 4 A 06/22/13 hospital History and Physical documented, "On visit 06/13 x-ray and CT (computed tomography) scan showed no evidence of pneumothorax or hemothorax. Back to ER on 06/22 for increased (symbol used) SOB (shortness of breath) and tachypnea. A chest x-ray demonstrated a near total whiteout of her left chest. The CT scan still demonstrated the left sixth and seventh rib fractures, but now shows an organizing left hemothorax....Will be taken to the operating room for a thoracoscopy, drainage, and debridement on 06/24/13." At 2:07 PM on 06/25/13 NA #1, who cared for Resident #3 on first shift, stated the transfer status of the residents was documented in the electronic FYI (for your information) section. She reported Resident #3's FYI section documented she was to be transferred using a Sabina lift or by using two staff members for manual transfers. However, she commented there were family members who did not want the staff to use the lift to transfer the resident. According to this NA, she had seen family members transfer the resident themselves by having the resident stand, hold onto an object, and pivot. She also reported she had seen other staff transferring Resident #3 by using a gait belt. The NA stated the resident was very unsteady and wobbly, and sometimes appeared anxious. At 2:28 PM on 06/25/13 Nurse #1, who cared for Resident #3 on second shift, stated the resident was at risk for falls upon admission due to confusion, unsteady balance, and history of falls and anticoagulant use. The nurse reported the FYI section, to which NAs were to refer for transfer instructions, documented Resident #3	F 323	Meeting with Management Nurses conducted by DON and included the topics as follows: no open-ended transfer orders to be part of medical record, each resident to have one (1) method designated for transfers (independent, gait belt with 1 assist, gait belt with 2 assist, stand-up lift, and dependent lift), comply with physician's orders; if change in resident condition occurs, seek appropriate order, and if family member(s) disagree with method of transfer, seek input from physician, PT, Social Worker, MDS Coordinator, unit nurse, Clinical DON, and Administrator to revisit and determine the appropriate but safest method of transfer. If no resolve obtained, contact the Regional Ombudsman to assist. "FYI" section's information for inactive residents can only be accessed in the care plan. Only active residents are accessible to Nursing Assistants. Quarterly and prn "Transfer As Ordered" audits will be conducted by the Quality Assurance Coordinator	

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F 323	Continued From page 5 was to be transferred using a Sabina stand up lift. However, she commented some family members wanted the resident transferred without using a lift. According to this nurse, there were times when Resident #3 was very wobbly, and it was better during these times to have two staff members complete transfers. She explained the NA who was assigned to the resident on 06/13/13 had put the resident to bed many times before, and should have known to use the lift to transfer the resident from her chair to the bed. The nurse commented it could have been the NA was rushed because staff were late getting residents to bed on 06/13/13 due to a severe storm, and the NA felt it was quicker to use the gait belt. However, she remarked, "I guess that is how accidents can happen." At 3:18 PM on 06/25/13 NA #2, who cared for Resident #3 on second shift including the night of 06/13/13, stated she had cared for the resident some when she was assigned to float, but had the resident on permanent assignment about two weeks before her 06/13/13 fall. She reported she transferred the resident as her family encouraged, by having the resident hold onto her neck and using the gait belt to lift the resident up out of the bed or chair. According to NA #2, she thought the FYI screen documented the resident was to be transferred using a gait belt. She commented she had not noticed Resident #3 having any balance problems until the evening of 06/13/13. On that night the NA explained she was late getting Resident #3 to bed because of a severe storm, but she stated she had removed the resident's top, slid her night gown over her head, and lifted her up out of a chair using the gait belt. She stated on their way to the bed the	F 323	and/or her designee, and the findings will be monitored by the QA Committee. The audit will include, but not be limited to, the following: noting transfer method utilized, presence of designated transfer in the care plan and "FYI" section of electronic charting, ascertaining MD order is preset and coincides with the care plan and the "FYI" section, name of staff member performing the transfer, and notation if counseling is deemed necessary. The facility, having six (6) units, will be "zoned" bi-Weekly . This Bi-Weekly Zoning Audit" will include a section for the zoning nurse(s) to ascertain that the type of transfer utilized by the nursing staff member is ordered in the medical record and noted in the care plan and the "FYI" section of the electronic charting system. These "zoning " audits will be conducted by the Clinical DON, the Director of Clinical Services, the SDC, the QA Coordinator and the MDS Department nurses (2 units on North Wing).	

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F 323	Continued From page 6 resident's feet became entangled with her own, and they both fell to the floor. At 3:42 PM on 06/25/13 the Therapy Manager (TM) stated there was a family member who wanted Resident #3 to be able to return home. Therefore, she explained this family member desired to preserve the resident's independence by having her complete transfers without the use of mechanical assistance. The TM also reported she received a 06/06/13 therapy referral for foot massages as Resident #3 transferred from TDWB to WBAT status. According to the TM, she examined the resident's left foot and interviewed the resident and family, ultimately deciding the massages would not be of benefit. However, the TM stated she did not complete an assessment of the resident's transfer capabilities because the staff reported no difference in her activities of daily living. At 3:56 PM on 06/25/13, during a telephone interview with Nurse #2 who cared for Resident #3 on first shift, she stated she thought the electronic FYI section documented the resident should be transferred using a lift or manually by two staff members. She reported she thought this was because the resident sometimes had balance problems. However, she commented she saw family having the resident stand and pivot during transfers. At 5:02 AM on 06/25/13 the Assistant Director of Nursing (ADON) stated the NA staff were trained to use the electronic FYI system to determine resident needs such as transfers. He reported ideally the staff was supposed to follow physician orders, but the facility was trying to accommodate	F 323	The SDC will present to the QA Committee quarterly evidence of all in-services conducted to ensure safe transfers of residents. Also, the SDC will present reports of non-compliance which will result in counseling and/or disciplinary action. All audits will be included in the quarterly QA meeting for review/comment of disciplines present. Corrective action will be completed by July 25, 2013.	

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F 323	Continued From page 7 and work with Resident #3's family to keep her as independent for as long as possible. The ADON commented he did not complete any disciplinary action or write up NA #2 after the 06/13/13 fall because he did not feel that she did anything wrong. According to the ADON, he reminded NA #2 to use the gait belt safely since she was transferring the resident as some of the family desired. Looking back on the care provided Resident #3 before the 06/13/13 fall, the ADON stated he thought the only thing the facility should have done differently was to obtain an open-ended order which allowed for some flexibility in how the resident was to be transferred based on assessment by the staff, family, and physician. He also reported the MDS Coordinator was the person who controlled input into the electronic FYI system. However, he commented the FYI information could not be viewed because the resident was no longer in active status, having been discharged to the hospital. At 8:55 AM on 06/26/13 the MDS Coordinator stated she used physician orders when placing care instructions in the electronic FYI system. She stated although the FYI information for Resident #3 could no longer be viewed, she was absolutely sure the FYI instructions for the transfer of Resident #3 on 06/13/13 were to use the Sabina lift with a 1 - 2 person assist. She explained the 03/26/13 physician order for use of the Sabina lift during transfers was the most recent prior to the resident's 06/13/13 fall. At 11:08 AM on 06/26/13, during a telephone interview with Resident #3's primary physician, he stated the resident had a history of blood clots	F 323		

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F 323	Continued From page 8 and blood thinner use when she entered this nursing home. He reported his expectation was that the facility keep the resident as safe as possible during transfers. He explained this would usually be done by staff working with the physician and therapy to formulate orders for the best care. He stated ideally he would like for a resident whose weight baring status changed to work with the staff and therapy to reassess the resident's transfer capabilities. At 11:32 AM on 06/26/13 the Administrator stated the facility tried to honor family requests/care preferences, but there were times when the best approach was to bring family, facility staff, and the physician together when there were differences in thoughts about what was the safest or most beneficial care for the resident. He reported the goal would be to have some good discussion between all participants, and reach some common ground.	F 323		