

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

PRINTED: 10/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN TRACE REHABILITATION & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 417 MOUNTAIN TRACE ROAD SYLVA, NC 28779	
(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 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to release lap belts during meals for 2 of 3 residents with restraints (Residents #2 and #8).</p> <p>Findings included:</p> <p>1. Resident #2 was originally admitted to the facility on 10/20/10 with diagnoses including dementia, hemiplegia and osteoporosis. The most recent Minimum Data Set dated 08/28/13 noted the Resident had highly impaired vision and severely impaired cognition, with inattention and disorganized thinking exhibited during the assessment period. Resident #2 required extensive two person assistance for transfers and was coded as using a trunk restraint in her wheelchair daily. Her care plan was last reviewed on 09/09/13 and included the problem of risk for falls with restraints noted as an appropriate intervention, due to poor safety awareness, with "release per protocol for meals, 1:1 care and check routinely" handwritten into the plan.</p> <p>A review of the Resident's medical record revealed an order on the September 2013 monthly physician order sheet for a non-self release belt secondary to poor safety awareness. Restraint assessment and informed consent</p>	F 221	<p>Plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provisions of federal and state law.</p> <p>Mountain Trace POC 9/24/13 thru 9/26/13 Complaint Survey</p> <p>1.F221 Residents #2 and #8 based on observation and record, review, and staff interview the resident's were not released during meals. residents #2 and #8 restraints were removed as soon as it was identified. Residents requiring staff assistance for release of restraints have the potential to be affected by this deficient practice although none were found to be affected.</p> <p>2. DON and SDC Immediately started to in-service staff on policy/procedure of restraints.</p> <p>3. Daily observation will be done and documented everyday times 1 month than 2 times a week times one month than weekly times 1 month. Findings of these observations will be presented to the QA Committee by DON on a monthly basis x's 3 then quarterly there after to determine the need for additional education or monitoring. New employees and contract employees will receive same education prior to working. Compliance date 10-26-13</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Mitchell Morrow

TITLE

Administrator

(X6) DATE

10/10/13

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 221	<p>Continued From page 1</p> <p>forms dated 04/02/13 and 04/09/13 respectively detailed the non-self release belt and were signed by the Resident's power of attorney.</p> <p>On 09/25/13 at 12:30 PM Resident #2 was observed in the main dining room, being fed by her husband. A non-self release padded lap belt was pulled across the Resident's abdomen and the ends of the belt were observed connected to the lower frame of the Resident's wheelchair.</p> <p>On 09/26/13 at 8:20 AM Resident #2 was observed in the main dining room, being fed by a family member. A non-self release padded lap belt was pulled across the Resident's abdomen and the ends of the belt were observed connected to the lower frame of the Resident's wheelchair.</p> <p>On 09/26/13 at 8:35 AM Nurse Aide (NA) #4 was interviewed. He stated he was assigned to the hallway where Resident #2 resided and that she wore a lap belt. He stated residents using lap belts were checked every 2 hours and belts were released for 1 to 1 care. He stated the Resident required full assistance with care and feeding with family or staff assisting with feeding and not leaving her unattended. The NA stated he was not sure if the lap belt was released during meals.</p> <p>On 09/26/13 at 8:45 AM Nurse #2 was interviewed. She stated lap belts were checked every two hours and released for incontinence care and for meals.</p> <p>On 09/26/13 at 8:50 AM Nurse #2 was observed checking Resident #2 in the main dining room while Resident #2 was being fed breakfast. The nurse stated the Resident's lap belt was not</p>	F 221			

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F 221	<p>Continued From page 2</p> <p>released. The nurse told another staff member the Resident's lap belt was to be released during meals. The nurse asked another staff member who brought Resident #2 into the dining room and she did not know. The nurse stated the expectation of staff to follow the Resident's care plan regarding restraint release which included release during meal times.</p> <p>On 09/26/13 at 3:39 PM the Director of Nursing (DON) was interviewed. She stated her expectation of staff to check lap belts every 30 minutes and release them every 2 hours and at every meal. She stated if there were issues, like a resident not being able to sit still, these would be discussed and a contingency would be built into the care plan.</p> <p>2. Resident #8 was admittred to the facility on 05/14/09 with diagnoses including atrial fibrillation, Alzheimer's Disease, osteoporosis and generalized anxiety disorder.</p> <p>The most recent annual Minimum Data Set (MDS) dated 07/20/13 indicated Resident #8 was severely cognitively impaired. The MDS further indicated she had highly impaired vision and had inattention and disorganized thinking. Resident #8 was assessed for most activities of daily living (ADL0 as requiring extensive assistance of two persons. Her balance was not steady and she was only able to stabilize with staff assistance. She was coded on the annual MDS as having a trunk restraint used daily.</p> <p>Review of Resident #8's medical record revealed consents signed by the responsible</p>	F 221	

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F 221	<p>Continued From page 3</p> <p>family member for the use of a self-release seat belt alarm dated 08/05/10, 10/21/11, 12/19/12 and 05/07/13.</p> <p>Review of a restraint assessment dated 04/13/13 revealed Resident #8's condition pertaining to her mobility included a closed fracture of her neck femur, a history of falls with poor safety awareness and dementia. She was assessed to slide forward in her wheelchair and required frequent repositioning. Least restrictive measures in use included removal of the self release belt alarm and frequent repositioning. The resident had several falls with skin tear injuries and the interdisciplinary team recommended continued use of the self release belt alarm due to her frequent sliding forward in her wheelchair and poor safety awareness.</p> <p>Review of resident #8's Care Area Assessment (CAA) Summary of 07/25/13 revealed the area of "trunk restraint" would be addressed on the resident's plan of care due to poor safety awareness, cognitive deficit, positioning, and her inability to release the restraint herself.</p> <p>Review of Resident #8's care plan for a problem of a risk for falls revealed an intervention to release restraint routinely for meals.</p> <p>An observation on 09/25/13 at 9:30 AM until 12:05 PM, just before lunch was served, revealed Resident #8 seated in her wheelchair at the table with Nurse Aide #1, Activities Director, Social Worker and the</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>Social Worker 's student participating in a tactile activity. Resident #8 was observed the entire time in the activity without being repositioned or having her seat belt released.</p> <p>An interview was conducted on 09/25/13 at 2:29 PM with Nurse Aide (NA) #1 who works from 7 AM to 3 PM and assigned to the 400 hall. She stated that several residents on the 400 hall need a lot of assistance and have been assessed as fall risks. She stated Resident #8 needs a self-release seat belt because she scoots forward. However, NA #1 said Resident #8 cannot release the belt and staff have to release it. She stated it has been difficult to attend to the residents needs on this unit because about 5 residents including Resident #8 have required the assist of 2 persons. NA #1 reported it has been difficult to release Resident #8's belt fequently unless she needs changed or laid down. NA #1 said an NA staff assigned to 300 hall and expected to float on the 100, 200 and 400 halls has been the only NA sometimes available to provide 2 person assist on the 400 hall. NA #1 reported that if the NA who floats has been providing care on the other halls she has not always been readily available to assist with resident care on the 400 hall. NA #1 revealed other nursing staff have been willing to help but if they have tasks to complete they have not always been available to provide immediate assistance on the 400 hall.</p> <p>An observation on 09/25/13 at 4:49 PM through 5:30 PM revealed Resident #8 seated in her wheelchair in the dining room with her dinner tray. NA #5 was observed providing</p>	F 221			

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F 221	Continued From page 5 assistance to the resident and had not released her belt for the entire dinner meal. An observation on 09/26/13 at 11:52 AM through 12:30 PM revealed resident #8 was seated in the dining room in her wheelchair with her lunch tray. NA #5 was providing feeding assistance to the resident and had not released her seat belt for the entire lunch observation. An interview was conducted on 09/26/13 at 12:35 pm with NA #5 about Resident #8 's seat belt and when it should be released. NA #5 stated the seat belt restraint should have been released during meals and she said she forgot and had not released it. An interview was conducted with the Director of Nursing on 09/26/13 at 3:37 PM. She stated her expectation with the use of restraints was they be checked every 30 minutes, released every 2 hours and at every meal. The Director of Nursing revealed she would schedule a mandatory inservice on restraints.	F 221			