STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	**1987 HILTON STREET BURLINGTON, NC 27217**

(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 resident interview, staff interviews, and record reviews the facility failed to used two staff member transferring residents using lifts which resulted in 1 of 3 sample residents (Resident # 2), who experienced falls, sustaining a laceration on the back of her head and a closed right clavicle fracture. Findings included: Resident # 2 was admitted to the facility on 10/7/2010 with diagnoses of with osteoarthritis and osteoporosis. A 7/24/2014 care plan identified Resident #2 being at risk for falls due to history of falls and the use of psychotropic medication. This care plan also specified " Requires extensive to total assistance with all ADL ' s (activities of daily living) and requires mechanical lift for transfer (sit to stand with transfer). " Transfer requires two person assistance during all transfer. The resident ' s Minimum Data Set (MDS) dated 7/24/2014 documented Resident #2 had moderately impaired cognition, and Resident # 2	F 323	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident # 2 was evaluated at the Emergency Room. Resident # 2 will have two employees to assist with transfer/lift at all times. Resident # 2 also is receiving Physical Therapy. Employee was educated 1:1 regarding two staff members at all times with any lifting	8/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/05/2014

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F 323	Continued From page 1 functional status revealed she was extensive assistance with one to two person physical assist with all transfers. An incident report on 7/12/2014 at 9:00 PM specified Resident #2 fell from sit to stand lift while a Nurse Aide was outside of the room getting towel to clean up urine on the floor. Resident # 2 was found on the floor at the foot of the bed with 1.5cm x 0.5 cm laceration on the back of her head. Review of Resident #2 medical record revealed a progress note written by Nurse # 1 on 7/13/2014 at 1:01AM which specified the resident fell from a sit to stand lift during bedtime preparation. The nursing assistant found the resident on the floor and contacted the nurse to assess the resident. The Resident was found at the foot of the bed on her back in a puddle of urine with blood coming from her head. The resident was assessed with a 1.5 cm x 0.5cm skin tear on the lower right side of her head. The site was cleaned with normal saline and a steristrip was applied to the laceration. The Nurse Practitioner was notified and neurochecks were ordered. The resident complained of pain in the right shoulder, back of the head and jaw and stated the jaw was from the impact of the fall. One injury was identified at the time of the assessment. That was the laceration to the back of the head. The resident also complained of nausea and dry heaved for 3-4 minutes with no emesis. The staff was to continue to monitor the resident. A Physician ' s Progress Note dated 7/13/2014 revealed a clinical impression of scalp contusion, closed right clavicle fracture and minor head injury post fall.	F 323	device and never to leave a resident alone in a lifting device. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice Nurse s and Certified Nursing Assistant s on staff will be in-serviced on Any resident who requires assistive lifting devices will have two staff members present when utilizing device. Measures to be put in place or systemic changes made to ensure practice will not re-occur A sample of 10% on each unit of residents requiring a device will be observed two times weekly x two to ensure 2 staff members are there, then weekly x two, than monthly x two. Results of these audits will be reviewed weekly at Risk meeting and presented findings at the October 2014 QA Meeting. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur A sample of 10% on each unit of residents requiring a device will be observed two times weekly x two to ensure 2 staff members are there, then weekly x two, than monthly x two. Results of these audits will be reviewed weekly at Risk meeting and presented findings at the October 2014 QA Meeting.	

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F 323	Continued From page 2	F 323		

A radiology report dated 7/13/2014 of a computed tomography (CT) head scan for Resident # 2 revealed a large posterior scalp hematoma.

A radiology report dated 7/13/2014 of a right shoulder radiograph for Resident #2 revealed a nonplaced fracture at the distal end of the clavicle.

An interview on 8/11/2014 at 9:30AM with Resident #2 revealed on 7/12/2014 NA #1 put her in a sit to stand lift and left her unsupervised in the room to go get a pillow chase for her bed. Resident #2 indicated during the time she was left unsupervised in the lift, all she remember was hitting the floor hard and hitting the back of her head. Resident #2 stated she was in pain all over and her head hurt badly. Resident #2 indicated that she was sent out to the hospital hours later because her pain got worst in her shoulder.

An interview on 8/11/2014 at 11:58AM with the Director of Nurses (DON) revealed that the facility policy has always been that two staff were needed to complete a lift transfer of any kind. The DON indicated that her expectation was for all Nurses and Nursing Assistants to have two persons to assist with lift transfer. The DON also indicated that the facility has completed a full investigation of Resident #2 falls.

An interview was conducted with Nurse #1 on 8/12/2014 at 12:15PM. Nurse #1 stated she was the Nurse on duty the evening of 7/12/2014 when Resident #2 fell from lift. Nurse #1 indicated that NA #1 found the resident on the floor on 7/12/2014 and came to her and stated that Resident #2 had fallen off the lift. NA #1 told her

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F 323	Continued From page 3 that she just stepped out of the room to get a towel and when she came back the resident was on the floor. Nurse #1 indicated that she and NA went into the resident ' s room. The resident was on the floor at the foot of her bed in a large puddle of urine and a growing puddle of blood near her head. Nurse #1 stated that she told NA #1 that " you know you are not supposed to leave anyone of the residents on a lift by themselves no matter how long. " A second attempt was make to call NA #1 on 8/12/2014 at 12:45PM no answer message left again. The facility indicated that on 8/11/2014 the NA called in sick and on 8/12/2014 the NA was off of work. A review of the written statement from the facility ' s investigation of the resident ' s fall revealed that the NA on 7/12/2014, NA #1 put Resident #2 on the sit to stand lift and when she elevated the lift Resident #2 started to urine on the floor. NA #1 went to get something to put under her and when she returned to the room Resident #2 was on the floor.	F 323		