STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

(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 staff interview and record review, the facility failed to put interventions in place to prevent recurrent falls for 1 of 1 cognitively impaired resident (Resident #1), with a known history of falls, from getting up without assistance, resulting in a fall with fracture. The findings included: Resident #1 was admitted to the facility on 9/19/14. Diagnosis included status post surgical repair of a fractured left femoral neck, chronic obstructive pulmonary disease and delusions. The hospital discharge summary dated 9/19/14 indicated the resident accidentally fell at home and fractured his hip. The nursing admission assessment dated 9/19/14 indicated the resident was alert and oriented to person, place and time and required extensive assistance with transfers. The Care Plan dated 9/19/14 included a problem of being at risk for falls. The goal included no fall related injuries during this assessment period. Interventions included to keep call bell within reach at all times, check on resident for their safety and staff to assist with all mobility. Resident #1's admission orders dated 9/19/14 included physical and occupational therapies.	F 323	All staff will be in-serviced on fall prevention and interventions. The falls prevention and intervention in-service will be completed by 12/5/2014. The DON, ADON, SDC and/or a nurse they designate will complete a Fall□s Risk Assessment on all residents. The Falls Risk Assessment will generate a Fall Risk Score based on a Resident□s cognition, vision, continence, skin integrity, mobility, medications, nutrition, and general health. Residents that score 0-6 are at low risk and residents that score 7-18 are at high risk of a fall. All resident□s Risk Assessment Fall Scores will be reviewed by the DON, ADON, and or SDC nurse to ensure proper interventions are in place and care planned appropriately. This will be completed by 12/5/2014. All resident□s care guides will contain a question asking if current fall intervention(s) implemented are effective. This question will be asked on each shift. If an implemented fall intervention is not	12/5/14

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

Electronically Signed | 11/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

(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	Continued From page 1 Physician orders dated 9/20/14 included an order for a psychiatric consultation for evaluation of possible dementia. The psychiatric consultation report dated 9/23/14 revealed Resident #1 had poor short and long term memory, poor insight and poor judgment. Diagnoses included depression and Alzheimer's disease by history. The admission Minimum Data Set (MDS) dated 9/26/14 revealed Resident #1 had severe cognitive impairment, no behavioral concerns, required extensive assistance with 2 people for transfers and was occasionally incontinent of bowel and bladder. Nurses' notes dated 9/25/14 at 2:24 PM, written by Nurse #1, revealed Resident #1 was walking around his room without assistance but was encouraged to call for assistance when needed. Nurses' notes and an incident report dated 9/29/14, written by Nurse #1, revealed Resident #1 fell at 3:15 PM while attempting to get up to the bathroom independently. The resident was assessed and no injuries were noted. The incident report indicated the resident was then assisted back to his wheelchair and toileted; hourly checks were begun and he was referred for restorative bowel and bladder training. During an interview on 10/29/14 at 4:45 PM, Nurse #1 recalled that Resident #1 told her he did not use the call bell because he thought he could make it to the bathroom himself. The nurse indicated the resident was put on hourly checks after the fall. The nurse explained hourly checks for 5 days was always implemented after a resident fell. A Restorative Aide (RA) note dated 10/1/14 at 2:55 PM, written by RA #1, indicated Resident #1 refused to be toileted 2 times and that the nurse was aware. During an interview on 10/29/14 at 11:30 AM, RA	F 323	being effective then the staff will answer appropriately and complete a Stop & Watch tool. The Stop and Watch Tool is a part of the INTERACT program and is an early warning tool identifying or observing a change in a resident□s status. A report of all interventions answered not effective and all Stop & Watch tools will be reviewed in the Interdisciplinary Team□s (IDT) daily morning meeting. For each resident where an intervention that has been reported not effective the intervention will be reviewed and an appropriate intervention implemented. This will be determined by including input about the resident from the Activities Department, Dietary Department, Social Services Department, Therapy, Nursing, and observations made by Maintenance, Environmental Services, and Administration. The DON, ADON, and or SDC nurse will verify in each chart, all implemented fall interventions. This will be documented on the Resident Fall Interventions Monitoring Tool. Further monitoring of the effectiveness of fall interventions will occur by members of the IDT. A minimum of at least 15 random residents a week for three months, with fall interventions, will be observed by a member of the IDT for fall intervention effectiveness. This observation will also include an interview with a Certified Nursing Assistant, and Nurse who have provided care for the Resident that day. The interview will include questions on the effectiveness of implemented fall interventions. The results of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

(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	Continued From page 2 #1 explained restorative bowel and bladder training included a restorative aide approaching the resident to take him to the bathroom every 2 hours. RA #1 recalled Resident #1 frequently refused to be toileted and would tell her he had already been to the bathroom or did not need to go. A Therapy note dated 10/1/14 at 5:48 PM indicated Resident #1 was trained on transfers with contact guard assistance for safety. During an interview on 10/29/14 at 10:28 AM, the Physical Therapy Assistant (PTA) who worked with Resident #1 recalled the resident was impulsive. The PTA indicated he reviewed safety precautions with Resident #1 frequently, including to use the call bell and get assistance prior to getting up. RA notes dated 10/3/14 at 1:41 PM, 10/4/14 at 2:31 PM and 10/6/14 at 3:07 PM indicated Resident #1 refused to go to the bathroom for bowel and bladder training. During an interview on 10/28/14 at 2:46 PM, Nursing Assistant (NA) #2 stated he frequently took care of Resident #1 on the 7-3 shift. NA #2 said the resident did not use his call bell much but was encouraged to do so. NA #2 indicated Resident #1 sometimes got up to the bathroom independently despite frequent reminders to call for help. During an interview on 10/28/14 at 5:25 PM, Nurse #4 indicated Resident #1 would get up by himself although he was not supposed to. She recalled that he became more confused during his stay. During an interview on 10/28/14 at 5:30 PM, NA #3 stated she had cared for Resident #1 on the 3-11 shift. She recalled the resident would get up by himself and not use the call bell. Nurses' notes and an incident report dated	F 323	observation and interview will be recorded on the Falls Intervention Effectiveness Tool. Results of the monitoring will be presented to the QA committee by the Administrator. Further monitoring will occur as directed by the QA Committee. All new admission□s Risk Assessment Fall Scores, from the Resident□s risk Assessment, will be reviewed at the interdisciplinary team□s morning meeting. Fall interventions that were implemented upon admission, if any, will be reviewed by the interdisciplinary team in its daily meeting. The interdisciplinary team may implement more interventions if needed based on each disciplines knowledge of the resident. The DON, ADON, and or SDC nurse will verify in each new admission□s chart, all implemented fall interventions, if any. This will be documented on the Resident Fall Interventions Monitoring Tool. The Administrator, Assistant Administrator, DON, ADON, and or SDC nurse will then verify that interventions documented on the Resident Fall Interventions Monitoring Tool are in place. This will be done for six months. Results of the monitoring will be presented to the QA Committee by the Administrator. Further monitoring will occur as directed by the QA committee. Residents will receive a Risk Assessment Fall Score from all significant change and quarterly risk assessments. The scores from the significant change and quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

(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	Continued From page 3 10/7/14 at 9:00 AM, written by Nurse #2, revealed Resident #1 was found on the bathroom floor and that he walked to the bathroom barefoot. He complained of pain in his left foot and was unable to bear weight on it. The physician was notified. A physician note dated 10/7/14 revealed Resident #1 was examined and found to have pain in his left foot when standing; he had good pulses and sensations. X-rays of the left hip and foot were ordered. An x-ray of the left femur dated 10/8/14 included: Impression: "Acute distal femoral shaft fracture with postoperative change." During an interview on 10/29/14 at 4:35 PM, Nurse #2 recalled that Resident #1 needed assistance but he frequently forgot to call for assistance prior to getting up and would say he thought he could do it on his own or that he forgot to use the call bell. The nurse stated the nursing assistants knew the resident got up by himself and would check on him more often. The nurse indicated she did not report that the resident continued to get up without assistance. The nurse also indicated Resident #1 became more confused during his stay and she obtained an order for a urine culture on 10/8/14. A nurse's note dated 10/7/14 at 9:47 PM, written by Nurse #3, indicated Resident #1 had tried to stand in the bathroom without assistance and hit his right arm causing a skin tear. The note went on to read, "While this nurse was on the phone with resident's (name of family member), resident got up from the wheelchair in his room falling over onto the floor hitting his back on the bedside table resulting in a 3 cm (centimeter) by 3 cm abrasion to his right flank. Resident refused to remain in bed or use the call bell. Resident has been brought out to the nurses' station for safety." During an interview on 10/29/14 at 11:24 AM, the	F 323	assessments will be reviewed at the interdisciplinary team□s morning meeting. Fall interventions that have been implemented, if any, will be reviewed by the interdisciplinary team. The interdisciplinary team may implement more interventions if needed based on each disciplines knowledge of the resident. The DON, ADON, and or SDC nurse will verify in the residents chart, all implemented fall interventions. This will be documented on the Resident Fall Interventions Monitoring Tool. The Administrator, Assistant Administrator, DON, ADON, and or SDC nurse will then verify that interventions documented on the Resident Fall Interventions Monitoring Tool are in place. This will be done for six months. Results of the monitoring will be presented to the QA Committee by the Administrator. Further monitoring will occur as directed by the QA committee. Any new resident falls will have an intervention implemented initially by the floor nurse. The fall intervention will be documented in the Residents Fall Interventions Flow Sheet. All falls and new interventions will be reported at the interdisciplinary team□s morning meeting by the DON, ADON and/or SDC. Previous and current interventions will be reviewed as well as any finding of a root cause. The interdisciplinary team will verify the intervention implemented by the floor nurse or implement a new fall intervention. The DON, ADON, and or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

(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	Continued From page 4 nursing assistant (NA #1) assigned to Resident #1 on 10/7/14 on the 3-11 shift stated when Resident #1 was first admitted he used the call bell and she would help him to the bathroom. NA#1 stated later on in his stay the resident stopped using the call bell and needed to be reminded not to get up without assistance. NA#1 added that on various occasions she saw Resident #1 coming out of the bathroom, either walking or in his wheelchair. During an interview on 10/29/14 at 5:33 PM, Nurse #3 recalled Resident #1 as being prone to get up by himself and had to be reminded frequently to call for help. Nurse #3 said on 2 different occasions when she was assigned to the resident she observed him picking up the call bell and speaking into it. She then explained to him how the call bell worked. The nurse stated she had the nursing assistants keep a close eye on him. Nurse #3 said she was told he fell on day shift on 10/7/14; that evening he did not complain of pain, would not stay in bed and kept trying to get up from his wheelchair. Physician orders dated 10/8/14 included an order to obtain a urine culture due to increased confusion. A nurse's note dated 10/8/14 at 1:53 PM indicated the physician was notified and Resident #1 was sent to the Emergency Room. During an interview on 10/30/14 at 11:45 AM, the Director of Nursing (DON) indicated that falls were discussed at the interdepartmental morning meetings, and interventions were added if deemed necessary. The DON indicated that in the case of Resident #1, he received ongoing occupational and physical therapy since admission and was placed on a restorative bowel and bladder program as an intervention following the fall of 9/29/14. The DON she expected staff to	F 323	SDC nurse will verify in the resident□s chart, all implemented fall interventions. This will be documented on the Resident Fall Interventions Monitoring Tool. The Administrator, Assistant Administrator, DON, ADON, and or SDC nurse will then verify that interventions documented on the Resident Fall Interventions Monitoring Tool are in place. This will be done for six months. Results of the monitoring will be presented to the QA Committee by the Administrator. Further monitoring will occur as directed by the QA committee WR Winslow Memorial Home submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

(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	Continued From page 5 notify the physician if the resident had behavioral changes to find a root cause. The DON indicated that since the facility did not use restraints or alarms, she did not know what else could have been done to minimize the risk of the additional falls. The DON explained that after the fall on the morning of 10/7/14, the resident was evaluated by the nurse practitioner and hourly checks were implemented. The DON added that after fall on the evening of 10/7/14, an order for a urine culture was obtained but the resident was sent to the Emergency Room prior to collection of the urine specimen.	F 323	or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. If the Provider meets the jurisdictional requirements, the Provider may be filling a request for an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process.	