STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

(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=D	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 interviews and record review the facility placed a dependent resident, at risk for falls, in a wheelchair without turning on a personal alarm; and the resident fell out of the wheelchair for 1 of 3 dependent residents at risk for falls (Resident #2). The findings included: Resident #2 was admitted to the facility on 08/09/14 with diagnoses that included history of falls at home, difficulty walking, osteoporosis and others. Resident #2's care plan dated 08/09/14 specified the resident was a fall risk and identified interventions to prevent the resident from falling that included: "observe at rounds for fall risk or behaviors, avoid clutter as possible, educate resident as able for safe movement, keep items within easy reach, observe for decline in level of consciousness or signs and symptoms of vertigo." The admission Minimum Data Set (MDS) dated 08/16/14 specified the resident had moderately impaired cognition, no behaviors, did not reject care but required extensive assistance with	F 323	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and /or executed solely because the provisions of Federal and State Law require it. . Following the fall on 9-2-14 the personal alarm was replaced with a new one. A Fall Investigation was conducted to review and discuss any needed interventions. Resident 2 discharged on 9-13-14. . All residents who have alarms have the potential to be effected by this alleged deficient practice. Resident who have personal alarms shall be checked for alarm functioning every two hours during residents' waking hours. . DON or designee shall conduct an in-service on fall prevention on December 18, 2014 for nursing, housekeeping, and	12/23/14

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

Electronically Signed | 12/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

(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 activities of daily living (ADL) and had fallen. Further review of Resident #2's medical record revealed a nurse's note dated 08/18/14 that specified Resident #2 had rolled out of bed but was not injured. A document titled "Profile of Incident" specified that on 08/18/14 Resident #2 was found sitting in the floor on her buttocks. The resident was not injured. Actions taken by the facility after the fall included fall mats placed beside the bed, bed in lowest position and a personal alarm placed under the resident. Resident #2 was to have her doors open, use personal alarms and frequent monitoring. A nurse's note dated 09/02/14 made by Nurse #1 read in part, the nurse was returning from lunch and was notified Resident #2 fell out of her wheelchair. A document titled "Profile of Incident" specified that on 09/02/14 at 9:25 AM Resident #2 was found by her family in the floor face down with the wheelchair turned over. Resident #2 had a skin tear to her left elbow and complained of hip and leg pain. A physician was in the facility at the time of the fall, assessed the resident and ordered Resident #2 to be sent to the Emergency Department for evaluation. The document also specified the resident's personal wheelchair alarm was not sounding at the time of the fall but was operational. The document specified that nurse aide #1 and nurse aide #2 were counseled about turning personal alarms "on" when applying them to a wheelchair. According to the document, Nurse #1 replaced the wheelchair alarm and sent the resident to the Emergency Department for evaluation. On 09/13/14 Resident #2 was discharged from the facility.	F 323	dietary. The in-service will focus on the monitoring of all personal alarms checking for function every two hours on awake residents. The nurse manager shall place an alert on the C.N.A. worksheet that a resident has a personal alarm. The C.N.A. shall monitor the functioning of the alarm every residents' waking two hours. Any alarm found to be non-functioning shall be replaced immediately. The C.N.A. shall initial the alert, once a shift, thus making a statement that this monitoring has been accomplished. Nurse managers shall monitor the C.N. A. worksheets on a daily basis to determine that C.N.A.'s are completing and initialing the task of monitoring the function of personal alarms. . To ensure solution is sustained the DON, ADON, or designee shall perform random audits for three times a week for one month on the placement and functioning of personal alarms. Following audits shall be conducted once a week for two months. The audits results shall report raw numbers of personal alarms checked and the raw numbers of non-functioning alarms found. Immediate corrective action will be taken when indication of non-compliance or alarms found non-functioning are identified. Audit results shall be reviewed in the monthly QAPI Meeting and revisions or adjustments made immediately as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

(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	F 323		

On 11/25/14 at 10:30 AM nurse aide (NA) #1 was interviewed and reported that she recalled Resident #2 and knew that the resident fell but could not recall details on 09/02/14.

On 11/25/14 at 10:40 AM NA #2 was interviewed and reported that she was assigned to care for Resident #2 routinely. She explained that Resident #2 was a fall risk and had several interventions in place to prevent falls such as fall mats at bedside, bed in lowest position, personal alarms on bed and wheelchair, and an anti thrust cushion to prevent the resident leaning forward out of the wheelchair and foot pedals with a cradle cushion to get her feet supported. NA #2 reported that Resident #2 required a special cushion that was lower in the back than the front because the resident often grabbed her stomach and would lean forward. NA #2 stated that on 09/02/14 the resident was grabbing her stomach and rocking back and forth while in the wheelchair. NA #2 also reported that residents with personal alarms were to have their alarms on at all times and it was the nurse aide's responsibility to ensure the alarm was working. NA #2 added that on 09/02/14 she provided Resident #2 her morning care that included using the mechanical lift to transfer Resident #2 from the bed to the wheelchair. NA #2 stated that NA #1 was present for the transfer. NA #2 explained that she removed Resident #2's personal alarm from the bed and applied it to the wheelchair but did not recall if she turned the alarm on or checked that it worked properly; but she stated she should have. NA #2 left Resident #2 in the room in her wheelchair with the call bell in reach. She stated that 10-15 minutes later Resident #2 fell out of the wheelchair and the alarm was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

(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	F 323		

turned on. NA #2 reported that Resident #2 was not capable of turning the alarm off.

On 11/25/14 at 11:00 AM the Assistant Director of Nursing (ADON) was interviewed and explained the facility's process for investigating falls. She explained that when a resident fell, it was the nurse's responsibility to asses the resident, notify the physician and the family, initiate an incident report and implement an immediate intervention to prevent a reoccurrence. The ADON added that the Administrative nursing staff reviewed incident reports to verify that new interventions were implemented and complete the fall investigation such as obtaining witness statements and making referrals. In the case of Resident #2, the resident fell out of bed on 08/18/14. The ADON reported that the administrative team decided to implement personal alarms to the bed and wheelchair, fall mats at the bedside only to be used when the resident was in bed and the bed to be kept in the lowest position. Resident #2 was working with physical therapy and occupational therapy; they made additional recommendations for wheelchair positioning that included an anti-thrust cushion and a foot cradle after the 08/18/14 fall. The ADON reported that fall interventions such as personal alarms were not items specified on the care plan because the nurse aides did not use the care plans when rendering care to residents. The ADON reported that nurse aides utilized assignment sheets. The ADON stated that after the fall on 08/18/14, Resident #2's assignment sheet was updated to reflect that personal alarms were to be attached at her bed and wheelchair at all times. The ADON also stated that nurse aides were expected to verify placement and function of the alarm before putting it to use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

(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 During the interview with the ADON, she reviewed Resident #2's fall on 09/02/14. The ADON reported that Resident #2 fell out of her wheelchair striking her chin on the floor and causing her wheelchair to turn over. She explained that during the investigation it was determined the personal alarm attached to Resident #2's wheelchair was not turned on. She reported that NA #1 and NA #2 were counseled for failing to check function of the personal alarm prior to placing it on the wheelchair and leaving the resident alone in the room in her wheelchair. The ADON provided a document that revealed NA #2 documented she had checked Resident #2's personal alarm on 09/02/14 but offered no explanation why the alarm failed to alarm when the resident fell out of the wheelchair. The ADON reported that the personal alarm was checked by Nurse #1 after the fall on 09/02/14 and determined that the alarm was functioning properly but the nurse replaced it anyway. The ADON stated that the resident was sent to the Emergency Department for evaluation, the nurse aides were counseled that alarms should be turned on; but no other interventions were implemented after the fall.	F 323		