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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 observations, staff and resident interviews and review of medical records the facility failed to raise the side rail and/or use safe technique when providing care to 1 of 3 sampled residents (Resident #46) and failed to keep the call light within reach for 1 of 3 sampled residents (Resident #46) reviewed for falls resulting in a fall in which Resident #46 sustained a fracture to her left humerus. Findings included: Resident #46 was admitted on 10/8/14 with diagnoses that included Vitamin D deficiency, anxiety, Alzheimer's disease, blindness in one eye, depression, chronic pain syndrome and hypertension. A 3/26/15 Fall Risk Evaluation revealed the resident was a HIGH RISK for falls scoring 23 (10 or above is high risk). The 3/26/15 Side Rail Safety Review indicated the recommendations were to have the right and left side rail up. The review indicated side rails were needed while the resident was in bed and served as an enabler to promote independence. The review indicated that while the resident had not requested the use of the side rails, she had fluctuations in her level of consciousness, visual	F 323	1) Corrective action has been accomplished for the alleged deficient practice in regards to Resident #46 by completing a Side Rail Safety Review and revising the care plan to reflect the use of side rails during care. The RCS Assignment Sheet was updated to reflect this intervention. A new call bell system on North Wing will be installed on or by August 4, 2015. The Director of Nursing conducted re-education for the Resident Care Specialist involved in the care of Resident #46 regarding safe technique while providing care for a resident in bed; specifically, the use of side rails, per the plan of care, for enhancing the Resident¿s ability to turn and reposition themselves while in bed and during personal hygiene in bed to reduce the potential for injury. 2) The Director of Nursing, Assistant Director of Nursing, and Unit Coordinator have conducted an audit of facility residents to identify that Side Rail Safety Reviews are in place and care plans are	8/7/15

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

Electronically Signed | 07/31/2015

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F 323	Continued From page 1 deficits, a history of falls, problems with balance or poor trunk control, and that while the resident may climb over the side rails, there was no risk to the resident if side rails were used. A 5/29/15 Quarterly Minimum Data Set (MDS) revealed Resident #46 was cognitively intact. No behaviors or rejection of care were identified. The MDS coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, toilet use, personal hygiene and total assistance for bathing. She was identified as occasionally incontinent of bladder and continent of bowel. The resident was not coded as having falls since the previous assessment. Review of Resident #46 ' s medical record failed to reveal a quarterly fall risk assessment or side rail safety review for June 2015 had been completed. A 6/16/15 psychiatric consultation indicated Resident #46 had blindness in the left eye. The physician noted per the neurological evaluation of November 2014, the resident's strength was decreased due to advanced age and deconditioning. The physician noted Resident #46 was alert and oriented to person. The physician documented the resident ' s thought process was logical. Her attention and concentration was noted to be intact while her memory, insight and judgement were moderately impaired. A Situation, Background, Assessment, Recommendation (SBAR) communication form and a nurse ' s progress note, dated 7/4/15 and signed by Nurse #1 at 7:10 AM, indicated the resident had been found on the floor on right side of the bed with the bedrails down. Resident #46 complained of pain in her left arm and shoulder. Nurse #1 documented Resident #46 had elbow swelling and bruises were noted to her upper	F 323	updated to reflect current needs of the residents. Side Rail Safety Reviews will be completed by a licensed nurse quarterly, annually, and with significant change in status as part of the MDS assessment process and be filed in the medical record. 3) Measures put in place to ensure the alleged deficient practice does not recur include: The Division Director of Clinical Education will conduct in-service education for the Interdisciplinary Team regarding the facility¿s Fall Management System which includes review of falls, care plan updates, and communication of interventions to be put in place to reduce the potential for injury. The Division Director of Clinical Education will conduct in-service education for nursing staff regarding the use of RCS Assignment Sheets. Specifically, resident care specialist will be educated that individualized interventions regarding falls prevention will be shown on the Assignment Sheets for residents, according to the plan of care, and interventions may be updated to address identified care needs. This education will also include keeping call bells within reach of residents who are able to use them. The Rehab Manager and Occupational Therapist will conduct in-service training for Resident Care Specialists regarding safe technique for providing care to residents while in bed; specifically, the use of side rails per the plan of care, for enhancing the Resident¿s ability to turn and reposition themselves while in bed	

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F 323	Continued From page 2 forearm. Nurse #1 completed an Interdisciplinary Post Fall Review on 7/4/15 with no time specified. The review indicated Resident #46 ' s fall had occurred at 7:00 AM. The nurse documented the resident had been found on the right side of the bed and the bed rails were down. The nurse practitioner (NP) on call was notified and X-rays were ordered. At 2:50 PM, the nurse noted the X-ray report was positive for a left shoulder/humerus fracture. The NP was again notified and an orthopedic consultation, ice to the left arm/shoulder three times daily and ibuprofen (a medication that helps relieve pain) 400 milligrams (mgs) three times daily for 1 week was ordered. Review of nurse ' s notes, dated 7/4/15 at 2:50 PM, indicated Nurse #2 documented she had medication Resident #46 for pain three times during her shift. She added the resident ' s arm remained swollen and bruised. At 7:30 PM on 7/4/15, Nurse #3, documented in the nurse ' s notes that Resident #46 was crying and complaining of left arm pain. He documented he called (name of NP) and received an order to send the resident to the Emergency Room (ER). The nurse documented the resident was transported by Emergency Medical Services (EMS) at 7:45 PM. Nurse ' s notes dated 7/5/15 at 4:00 AM, indicated Resident #46 had returned to the facility with a sling in place to her left arm. He noted the resident ' s pain seemed to be controlled with the Ibuprofen. The nurse noted the resident was alert to person and place. The Investigation Follow Up, completed by the Director of Nursing (DON) #1 with no date for the investigation, indicated the incident occurred on 7/4/15. Summary of the investigation revealed	F 323	and during personal hygiene in bed. The Director of Nursing and/or Assistant Director of Nursing will conduct random audits of 10 residents per week for 4 weeks, then 10 residents a month for 3 months to ensure side rails are in use as indicated. The Director of Nursing and/or Assistant Director of Nursing will conduct audits of RCS Assignment Sheets to ensure information is updated and reflects the care plan weekly for 4 weeks, then monthly for 3 months. The Interdisciplinary Team will conduct daily audits of call bell placement for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. The Rehab Manager, Director of Nursing, and/or Unit Managers will conduct 10 random care audits while residents are in bed 4 times per week for 4 weeks and then 4 times per month for 3 months to ensure safe technique is utilized. 4) The Administrator or Director of Nursing will review data obtained during audits to analyze the data and report patterns/trends to the QAPI Committee Weekly for 4 weeks then monthly for 3 months. The QAPI committee will evaluate the effectiveness of the above plan and will add interventions based on identified trends/outcomes to ensure continued compliance.	

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staff reported resident sometimes tried to get up alone. This time, the DON documented, Nursing Assistant (NA) #1 was providing incontinent care. His left hand was on the resident ' s hip to stabilize her and the side rails were down. When he reached for a brief, the resident fell from the bed. Under Recommendations and New Interventions, the DON documented a scoop mattress and a reminder to raise the rail or work in front of the front side of the resident versus pushing the resident from behind.
The care plan for Resident #46, reviewed on 7/20/15, Resident #46 was at risk of falls and required extensive assistance with her activities of daily living (ADL) due in part to recent falls, utilization of assistive devices, decreased muscle coordination, arthritis, osteoporosis, and use of psychotropic medications. The goals were Resident #46 would not sustain injury from a fall and ADL needs would be identified and met with staff assistance while maintaining her highest level of independent function. Approaches to attain the goals included encouraging the resident to ask for assistance, therapy as needed, call light in reach, toilet frequently and to keep frequently used items in reach. On 7/4/15, a hand written notation indicated the scoop mattress had been added.
At 8:22 AM on 7/21/15, Resident #46 was observed in bed eating breakfast. The call light was on the left side of the bed out of the resident's reach. When asked if she could reach the call bell to request assistance, the resident stated " no " . She added the call bell was on her left side and she had broken her arm and could not move her arm to reach the bell. A sling was observed to her left arm. The resident stated she had been dropped by 2 men transferring her. She was unable to recall the time, date or the

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F 323	Continued From page 4 names of the people involved. Nurse #1 was interviewed on 7/22/15 at 8:17 AM. She stated she was the nurse assigned to care for Resident #46 and was on duty during the 11 to 7 shift when the resident had fallen. Nurse #1 stated NA #1 had been providing incontinent care. She stated he told her he had rolled the resident on her side. When he reached for a brief, the resident continued to roll and fell to the floor. Nurse #1 added the fall occurred right at 7:00 AM and she and Nurse #4 checked the resident over. She stated at the time of the fall, Resident #46 complained of pain and stated her arm was broken. The nurse added the on-call physician was notified and X-rays were ordered. Nurse #1 described Resident #46 as alert and oriented but at times could be confused. An observation was made on 7/22/15 at 8:55 AM. The resident was lying in bed. Her sling was on her left arm shoulder. The call bell was observed lodged between the wall and the bed rail with the end of the call bell that needed to be pushed lower than the edge of the bed. The dinner bell (also used to call for assistance) was on the over bed table approximately 3 feet on the right side of the resident and out of reach. Resident #46 stated if she needed to call for help, she did not know how she would call. She added she was right handed and she could not reach over her body and try to get the call bell. She added the dinner bell was also out of reach. NA #2 was interviewed at this time. She stated she had been assigned to care for Resident #46. The NA stated the resident could use both her right and left hand. On observation, the NA stated the call bell was not within reach and with the sling, the resident's mobility was limited. The NA had to move the entire bed to dislodge the call bell and place it within reach of the resident. She added	F 323		

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the dinner bell was also out of the resident's reach.
A telephone interview with NA #1 was held on 7/22/15 at 9:55 AM. He stated he had been assigned to care for Resident #46 on 7/4/15 when she fell. NA #1 stated he was providing incontinent care for Resident #46. The NA added both side rails were down at the time he was providing the care. NA #1 described the incident by saying he had placed his right hand on the resident ' s hip and with his left hand had reached toward the end of the bed for a brief. As he reached for the brief, Resident #46 continued to roll out of bed, landing on her left side. The NA stated he knew that previously, when the resident had lived in a different room, one side rail had been raised. When he reported for his shift the night of the resident ' s fall, the side rails were both down, so he left them down, even when providing care and the resident required turning from side to side. The NA stated the position of Resident #46 ' s side rails, up or down, varied depending on what staff member worked. The NA added prior to the 7/4/15 fall, he would not have considered her a fall risk. The NA stated if a resident were a fall risk, the information was found in the resident's chart, the nurse would tell the staff or the information could be found on the NA assignment sheet at the nurse's station.
NA #2 was interviewed on 7/22/15 at 10:17 AM. The NA stated if a resident had been identified as a fall risk, the information is passed from shift to shift or could be found on the assignment sheet next to the resident ' s name. Review of the assignment sheet revealed Resident #46 had not been identified as a fall risk. The NA stated she was unaware Resident #46 was a fall risk. The NA stated she had to move the bed this morning to get the call bell from behind the bed. She

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stated she had moved the dinner bell out of Resident #46 ' s reach when she removed the breakfast tray and had forgotten to place the bell within the resident ' s reach. The NA stated the resident required assistance for getting out of bed, could take a few steps but required hands on assistance for stabilization. NA #2 stated Resident #46 had not attempted to get out of bed independently while she had worked with her.
During a telephone interview with Nurse #4 on 7/22/15 at 10:30 AM, she stated she had just arrived for her 7 to 3 shift on 7/4/15 when another staff member said Resident #46 had fallen. The nurse added she and Nurse #1 went to the resident ' s room. At the time of the fall Resident #46 complained of pain in her left shoulder. Nurse #4 stated she saw no obvious shoulder deformities. Nurse #4 added while Nurse #1 completed the assessment, she called the on call physician. She stated she was not assigned to the resident for 7/4/15
Nurse #2 was interviewed on 7/22/15 at 10:51 AM. Nurse #2 stated she had been assigned to care for Resident #46 during the 7 to 3 shift on 7/4/15. The nurse added when she arrived to work around 7:00 AM, she received report the resident had fallen. Nurse #2 stated she first saw Resident #46 between 8:30-9:00 AM. She added she found the resident alert and oriented and complaining of pain. The nurse stated she told the resident she had received pain medication. Nurse #2 stated the resident next received Tylenol 650 mg at 10:45 AM. At 1:30 PM, she received Ultram (a type of pain medication. By the end of the shift, the resident's pain seemed under control.
An interview was held with DON #1 and DON #2 on 7/22/15 at 11:36 AM. The DONs stated information, including fall risk was pulled from the

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board in the conference room and reviewed during morning meetings. They added information about fall risk would be added to the new assignment sheets that would be placed this week. The DONs added the Unit Managers also attend morning meetings and take the information, such as fall risk, back to the staff on the floors. The DONs reviewed the NA assignment sheets currently used and stated the sheets did not have enough information about residents. They acknowledged Resident #46 had not been identified as a fall risk.

DON #1 was interviewed on 7/22/15 at 12:13 PM. The DON stated her expectation was for the call bell or the dinner bell to be within reach of the resident. She added quarterly fall assessments were completed by the MDS nurse. DON #1 added if a resident was assessed as a high risk for falls, the falls risk should be care planned and information for fall prevention and risk relayed to the direct care team. The DON stated side rail assessments were also completed by the MDS nurse. The DON reviewed the side rail assessment for Resident #46 and added the assessment indicated her side rails should be raised to increase independence. In order to determine side rails should not be used, the use of side rails should also be reviewed by the interdisciplinary team.

Nurse #3 was interviewed on 7/22/15 at 3:02 PM. The nurse stated he worked with Resident #46 during the 3 to 11 shift on 7/4/15. He stated he received the information about Resident #46 ' s fractured arm when he arrived to work. After report, at approximately 3:30-4:00 PM, Nurse #3 stated he assessed Resident #46 and she was resting. The nurse stated later in the shift, he reassessed the resident and she stated she was in pain. He offered pain medicine, but added she

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only had Ultram and Tylenol was not a very strong pain medication. Nurse #3 added the resident stated she wanted to go to the hospital, so he called the on call provider (the NP). The nurse stated he explained the resident's pain and the fact she wanted to go to the hospital and received the orders to go to the hospital. The nurse stated the resident was alert and oriented, but forgetful. The nurse added Resident #46 was able to use a call bell and had used her call bell before.

The resident was observed on 7/23 at 7:40 AM. She was lying in bed with diathermy (a therapy treatment to lessen pain) being administered. The resident stated she was unable to reach her dinner bell and demonstrated by extending her arm fully. The call bell was approximately 12 inches out of reach. She stated she had tried to call for help, but could not reach the call bell.

NA #3 was interviewed on 7/23/15 at 7:45 AM. She stated she had checked on Resident #46 at approximately 6:30 AM. The diathermy she stated, had been placed by the therapy department around 7:00 AM. NA #3 observed Resident #46 ' s call bell and her unsuccessful attempt to reach the call bell. The NA stated therapy staff should have either placed the over bed table within the resident ' s reach or placed the bell in the resident's bed so she could call for assistance when needed.

DON #2 was interviewed on 7/23/15 at 9:58 AM. She stated she and DON #1 were responsible for the fall program. She stated when she started working at the facility, she identified there was a problem with the fall program and she has since tried to implement a program. The DON gave the surveyor the Performance Improvement Project (PIP) for review. The initiation date of the PIP was 6/16/15. The date completed was blank and

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the status was designated as on-going. Under Plan- Root Cause, the DON had written "fall management system/tracking currently not in place. Obstacles-" need to formulate fall management system for tracking/prevention /IDT meeting; Projected Outcome-"falls to be tracked for appropriate measures, tracked and trended, care plan updates/Resident Care Specialist (RCS) sheet updated with interventions implemented/fall risk identified On the second page, titled "DO", under #1 the action item was implement IDT for fall management, driver -nursing, start 6/16/15 and target completion date-ongoing. Resources needed-falls to be reviewed in stand up meeting for appropriate intervention/documentation, complete post fall review with IDT, identify root cause and identify. #2 Action - to track and update RCS sheets and care plans, driver-nursing, start 6/16/15, target completion date ongoing and resources needed-revision of (name of corporation) RCS sheet versus current RCS sheet in use, update care plan (CP) when falls occur with interventions #3 Action Item- In-service education or falls, prevention of falls, incidents/accidents injury Driver-nursing Start 6/16/15, ongoing, Resources- educational data for fall prevention and injury. The DON stated so far, she had been unable to update the sheets used by direct care staff for provision of care and no formal educational sessions for fall prevention had been held. She added all their attention and focus had been placed on returning the facility to compliance. The DON stated the Unit Manager (UM) was responsible on a daily basis for making sure fall prevention interventions are in place. She added the expectation was the UM would make rounds daily and make sure all fall prevention items were in place. The DON was

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unable to give a reason as to why Resident #46 ' s call bell had not been in place and within the resident ' s reach for 3 observations over 3 days. The DON added if the side rail had been raised during the provision of care on 7/4/15, Resident #46 would not have fallen.
The Certified Occupational Therapy Assistant (COTA) was interviewed on 7/23/15 at 10:32 AM. The COTA stated she had placed the diathermy machine into Resident #46 ' s room between 7:00 AM-7:30 AM. She stated on entering the room, the resident ' s over bed table with the dinner bell was beside the resident and within reach. The COTA stated when she left Resident #46 ' s room she made a mistake and had not placed the bell where the resident could reach the bell. She acknowledged without the bell in reach, the resident would not be able to call for assistance.
The MDS Coordinator was interviewed on 7/23/15 at 11:53 AM. She stated she was responsible for all quarterly assessments. She added if a resident was assessed as needing side rails, she tries to add side rails to the ADL care plan. The MDS nurse stated the UM was responsible for updating the sheet used by the NAs for provision of resident care. The MDS nurse reviewed the side rail safety review, dated 3/26/15 and stated she had completed the review. She stated according to her assessment and the documentation on the sheet, side rails were indicated and serve as an enabler to promote independence for Resident #46. The MDS nurse added this meant the side rails were used by the resident during incontinent care to help her pull over. The MDS nurse stated she was responsible for placing side rails as an enabler on the ADL care plan and the UM was responsible for placing the side rail information on the NA care sheet. The MDS nurse reviewed the ADL

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	345232	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHABI HICK	**3031 TATE BOULEVARD SE HICKORY, NC 28602**

(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 11 care plan for Resident #46 and stated she had forgotten to add the side rails as an enabler. The MDS nurse stated she knew Resident #46 used side rails. She was aware the resident fell, but was unaware how the fall occurred and she was unaware the side rails were not in an up position. The nurse stated logic would tell you that if the side rails had been up Resident #46 would not have fallen out of bed during incontinent care and the fracture would have been avoided. The fall that resulted in the fall on July 4th could have been prevented if the side rail had been up. The MDS nurse stated the quarterly fall assessments and side rail assessments were behind because the state came in and all efforts had been placed on doing more assessments to capture residents on therapy. The UM for the area where Resident #46 lives was interviewed on 7/23/15 at 12:30 PM. The nurse on the hall or the MDS nurse is responsible for updating care plans after a fall. The UM stated she was unsure if Resident #46 was supposed to have side rails, but she used the side rails for bed mobility. The UM stated she knew the resident had fallen. NA #1 told her she had rolled off the bed during provision of care. The UM stated she had asked the NA if the side rails had been up during care and he had told her no. She stated she had asked him why he had not placed the side rails in an up position during care and received no reply from the NA. The UM stated if the rail had been up, the resident probably would not have fallen. If she had not fallen her arm would not have broken. The nurse stated the broken arm could have been prevented.	F 323		