STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345124	A. BUILDING _____ B. WING _____	C 11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ELKIN	660 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 record review and staff interview the facility failed to follow safety measures during turning a resident in bed for 1 of 3 sampled residents who were totally dependent on staff for activities of daily living (Resident #1). As a result, the resident fell out of bed sustaining skin tears, hematomas and bilateral fractures of the lower extremities. The Findings included: Resident #1 was admitted to the facility on 7/29/10 with a diagnoses that included dementia, difficulty walking, vertebral fracture, rib fracture, renal and ureteral disease, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated 7/17/15 indicated Resident #1 required total assistance of 2 persons for bed mobility. Resident #1 was totally dependent with 1 person assistance for bathing and had impairments of both upper and lower extremities. The MDS further indicated Resident #1 was severely cognitively impaired. Review of the resident ' s care plan updated 8/17/15 indicated a " problem " of Resident #1 was impaired with activities of daily living (ADL) related to severe dementia, history of lacunar	F 323	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. **IMMEDIATE CORRECTIVE ACTION:** 1. Resident observed for injuries by the Licensed Nurse 2. Resident was sent to the ER for evaluation 3. C.N.A suspended pending investigation 4. Met with C.N.A and provided log rolling education with emphasis on log rolling during bed bath and rolling resident toward C.N.A.	12/1/15

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

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F 323	Continued From page 1 infracts and cardiovascular accident. She had deformities of bilateral hands and contracture to her legs and feet making her dependent on staff for all ADLs. Review of Resident #1 ' s care plan dated updated 8/17/15 indicated a " problem " of Resident #1 potential for falls related to Resident #1 ' s impaired ability to transfer herself. Resident #1 was dependent on staff for transfers and was non-ambulatory. The goal stated Resident #1 would not have a fall through the next review. The approaches included transfer with total lift, bed in low position, and maintain safety with transfers. Review of Resident #1 ' s incident report dated 10/12/15 revealed Resident #1 had a fall from her electric bed (Bed B) which resulted in a skin tear, abrasion, and hematoma. The incident report stated, the resident was found semi-seated on the floor leaning with her back against bed A (the bed of Resident #1 ' s roommate) and head on the mattress of bed A. Resident #1 ' s legs were on the floor toward the window. Emergency medical services, medical doctor and responsible party were notified. The body check revealed Resident #1 had hematomas on the left and right knee and skin tear/abrasion on the left foot and right hand. The resident was transferred to the hospital. The incident report indicated that the facility was notified by the admitting hospital that Resident #1 had fractures of the lower extremities. The " involved persons statement " section of the incident report indicated NA#1 stated, " I was giving resident bed bath and I had finished front and rolled resident over to wash backside. Rolled resident away from me when resident feet feel off bed and the resident of her body rolled out as I tried to hold onto her. Resident went off bed onto	F 323	**METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED** A 100% audit, completed by the Director of Nurses, Assistant Director of Nursing, Clinical Competency Coordinator and the Administrator, of the residents that are total care and unable to hold on to the side rail to identify the residents at risk. Residents identified at being at risk will have care plan updated with assistance needed during care in the bed. **SYSTEMIC CHANGES TO PREVENT DEFICIENT PRACTICE.** • Education began on Oct 12, 2015, by the Clinical Competency Coordinator and Nurse Management team, for certified nursing assistance related to turning and positioning resident's in bed, and completing ADL care in bed. Any staff that have not completed the in-service will not be permitted to work until the in-service is completed. Education was added to new partner orientation. • The Nurse Managers and Licensed Nurses will observe 4 – 5 residents ADL care in the bed per 24 hours for 14 days than 10 observations per week for 4 weeks, then 10 observations monthly.	

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F 323	Continued From page 2 knees and onto backside. I immediately called for the nurse. ¼ (quarter) rails were up on both sides of the bed. Bed was approximately 3 to 4 feet high due to CNA giving bed bath " . Review of the History and Physical (H&P) from the hospital indicated Resident #1 was admitted on 10/12/15. The H&P stated Resident #1 presented to the hospital after a fall injury that occurred at the nursing home. In the Emergency Room the patient was evaluated and it was found that the patient had a fracture to the distal left femur and also right tibia. The assessment and plan provided pain control with oral and intravenous pain medications as needed. The assessment continued with Resident #1 would most likely not be a surgical candidate. Review of Resident #1 ' s Discharge summary from the hospital dated 10/19/15 stated, " assessment/Plan " fall with resultant distal left femur fracture and right tibia fracture. No surgery was recommended. The discharge summary stated, " Conservative management per medical doctor. " Interview with Nursing Assistant (NA#1) on 11/23/15 at 12:46pm revealed on the day of the fall she was giving Resident #1 a bed bath. When she turned Resident #1 over to do her backside Resident #1 kicked her legs off the bed and she went over onto the floor. Resident #1 fell off the bed feet first. NA#1 stated she had Resident #1 ' s bed elevated to provide care. NA#1 stated she was the only one in the room providing Resident #1 with care/bed bath. NA#1 further stated Resident #1 was a 2 person transfer. NA#1 revealed a 2 person transfer meant two people were needed to provide care	F 323	• The Nurse Managers and Licensed nurses will provide the Clinical Competency Coordinator (CCC) the results of their ADL observations for tracking and trending. **HOW WILL CORRECTIVE ACTION BE MONITORED?** The Clinical Competency Coordinator will correlate the ADL care preformed in the bed observation data and present findings t the Quality Assurance and Performance Improvement committee monthly for 3 months for recommendations.	

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F 323	Continued From page 3	F 323		

including bed baths, positioning and turning. NA#1 stated she did not know why she didn ' t get another staff to assist. She further stated, " I didn ' t want to pull anyone off their hallway. " NA#1 indicated she rolled Resident #1 away from her. The facility trained staff to turn the resident toward staff but NA#1 indicated she rolled her away. Both bedrails were up at the time of the incident.

Interview with the Assistant Director of Nursing (ADON) on 11/23/15 at 12:56pm revealed she got called down to Resident #1 ' s room following the fall that occurred on 10/12/15. Resident #1 was laying in the floor when the ADON arrived at the resident ' s room. Resident #1 was located In-between bed A and B. The ADON stated Resident #1 ' s head was lying near her roommate ' s bed and her feet were toward her bed. The ADON stated she was told by NA#1 that NA#1 was giving Resident #1 a bed bath. NA#1 told the ADON she had turned Resident #1 and her legs started off the bed and she couldn ' t hold Resident #1. The ADON revealed NA#1 rolled Resident #1 away from her instead of towards her. Resident #1 required the assistance of 2 persons at the time of the fall. The ADON stated she believed it was an honest mistake on NA#1 ' s part. The aides knew what type of assistance needed for each resident because it was communicated verbally and there was a book on the hall that contained resident care plans.

Interview with Director of Nursing (DON) on 11/23/15 at 1:05pm revealed she got called down to Resident #1 ' s room following the fall on 10/12/15. When she got to the room, Resident#1 was on the floor between bed A and Bed B. The

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F 323	Continued From page 4 DON stated there was quite a bit of blood from skin tears Resident #1 sustained due to the fall. The DON revealed NA#1 turned Resident #1 while providing a bed bath when resident #1 kicked her leg off the bed. Resident #1 body followed her legs over the bed and onto the floor. The facility called the medical doctor and Resident #1 was ordered to the emergency room for evaluation. The DON indicated she did not know why NA#1 was trying to do Resident #1 ' s care by herself. NA#1 rolled Resident #1 away from her. NA training during orientation included safety measures to include rolling a patient toward the NA not away from them. Interview with the Administrator on 11/23/15 at 1:15pm revealed on the day of the incident she was called to Resident #1 ' s room. The Administrator stated she saw resident #1 on the floor with both legs out in front of her. Resident #1 ' s head was on her roommate ' s bed and legs were towards her bed. Resident #1 was observed to have skin tears following the incident and had no obvious signs of pain at the time. The Administrator revealed she immediately questioned NA#1 about what had occurred. NA#1 told the Administrator that while providing Resident #1 with a bed bath Resident #1 kicked out resulting in Resident #1 falling off the bed. The Administrator stated it was out of the ordinary for Resident #1 to kick out. The Administrator indicated NA#1 was suspended pending a facility investigation. The administrator revealed NAs had gotten comfortable with providing care with the assistance of 1 person because Resident #1 did not move. Resident #1 was coded on the MDS as requiring total care. It was found that NA#1 had rolled Resident #1 away from her and not towards her.	F 323		

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F 323	Continued From page 5 Interview with the Administrator on 11/24/15 on 9:39am revealed her expectation that staff roll the patient toward them not away from them during ADL care.	F 323		