STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

(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: F323-D Based on observation, staff interviews and records review, the facility failed to prevent a resident fall by the wound consultant leaving the bedside while the bed was raised in the high position and the resident rolling out of the treatment nurses grasp (Resident 5) resulting in occipital hematoma and laceration for 1 of 3 residents reviewed for accidents. Findings included: Resident #5 was originally admitted to the facility on 1/15/10 and readmitted on 4/18/16 with cumulative diagnoses of fall, contusion to her scalp, urinary tract infection, cerebral vascular accident and hemiplegia. Resident #5 ' s Annual Minimum Data Set (MDS) dated 9/14/15 indicated severe cognitive impairment with verbal behaviors only. She required extensive assistance with her bed mobility, total assist with transfers, and was coded as non-ambulatory. Resident #5 was also coded as having no falls and no side rails. The quarterly MDS dated 11/10/15 indicated Resident #5 had severe cognitive impairment with delusions. She required extensive assistance with her bed mobility, total assistance with transfers	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F323 Corrective Action for Affected Residents Resident # 5 was sent to hospital on 04/12/16 for evaluation post fall. The resident returned to the facility on 04/18/16 following hospitalization for Delirium and UTI. The resident's kardex was reviewed and updated by the Interdisciplinary Care Plan Team on 04/18/16. New interventions included two person assistance with care while in bed. Corrective Action for Potentially Affected Residents	5/18/16

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

Electronically Signed | 05/18/2016

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F 323	Continued From page 1 and she was non-ambulatory. She was coded as having no falls and no side rails. The quarterly MDS dated 2/5/16 indicated Resident #5 had severe cognitive impairment and verbal behaviors. She required extensive assistance with bed mobility, transfers and she was coded as non-ambulatory. She was also coded as having no falls and no side rails. Resident #5 ' s care plan dated 2/5/16 indicated she was care planned for an increased risk for falls due to a lack of safety awareness, paralysis, confusion deconditioning and psychoactive medication usage. Interventions included staff anticipating and meet her needs, offering divisional activities, monitoring and documenting any falls for 72 hours post fall, observation for adverse medication side effects and reviewing any past falls for the root cause. The 5-day readmission MDS dated 4/22/16 indicated Resident #5 had severe cognitive impairment, no behaviors, required total assistance with all of her activities of daily living to include bed mobility. She was also coded for one fall with injury and for the use of no side rails. Resident #5 was care planned dated 4/18/16 for the risk of falls due to her impaired cognition, hemiplegia, and deconditioning and psychotropic medication usage. The only new intervention was for two person assistance for care while Resident #5 was in the bed. A review of an incident report dated 4/12/16 indicated at 3:05 PM, the treatment nurse and the wound consultant were in the room performing a pressure ulcer assessment when Nurse #1 heard the treatment nurse call out for help because Resident #5 was on the floor. When Nurse #1 entered the room she noted the bed in the high position and Resident #5 had an apparent head injury. There was blood coming from the back of	F 323	All residents who are dependent for bed mobility have the potential to be affected by this alleged deficient practice. Beginning 05/12/16 the nurse managers began reviewing all current residents to identify which residents required extensive to total assistance with bed mobility. This was accomplished by running a report from the response analyzer report from Point Click Care to identify residents that require extensive to total assistance with bed mobility on their most recent MDS. Residents were then reviewed to identify if they were able to assist with bed mobility and what interventions were needed to prevent them from rolling out of the bed. Interventions may include assigning two assistants for bed mobility, adding a grab bar for the resident to hold onto if indicated, adding a bolster or scoop mattress if indicated, adding wedges for boundaries, and other interventions based on the individual residents need. This process was completed on 05/18/16. A new quality assurance process was put in place on 05/17/16 that included assessing all new and readmissions to determine if the resident is in need for additional interventions to prevent them from rolling out of the bed. This will be completed by reviewing the completed risk assessment User Defined Assessment section D for mobility. Residents that are unable to independently assist with bed mobility will be reviewed for additional interventions such as assigning two assistants for bed mobility, adding a grab bar for the resident	

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F 323	Continued From page 2 Resident #5 ' s head. The physician, emergency medical services (EMS) and the responsible party were notified of the fall and Resident #5 was sent to the hospital for an evaluation. The incident report further indicated the resident was on an air mattress and Resident #5 maneuvered to close to the edge of the bed during her treatment. A review of the hospital admission paperwork dated 4/12/16 indicated Resident #5 was total care dependent at the nursing home and came in due to a fall and delirium. EMS reported Resident #5 rolled off the bed during wound care and sustained a hematoma and laceration on the occiput of the head. Resident #5 ' s hospital scans of her head and neck indicated no acute hemorrhage or fractures. Resident #5 was admitted to the hospital and treated for delirium and a urinary tract infection until 4/18/16 as which time she was discharged back to the facility. The director of nursing (DON) obtained statements from the treatment nurse and wound consultant on 4/14/16. The treatment nurses statement indicated she and the wound consultant were both in Resident #5 ' s room administering care to her sacral wound at the time of the fall. Resident #5 was rolled onto her right side while she was on the left side of the bed with her hand on Resident #5. Resident #5 slipped from the treatment nurses ' grasp and fell out of the bed onto the floor. The wound consultant was near the treatment cart at the corner of the bed at the time of the incident. The wound consultant ' s statement dated 4/14/16 indicated he was in Resident #5 ' s room at the time of the fall. He stated he left the side of the bed to input information into his computer at the foot of the bed and in less than a minute, Resident #5 had fallen to the floor. He stated the treatment nurse was at the bedside at the time of	F 323	to hold onto if indicated, adding a bolster or scoop mattress if indicated, adding wedges for boundaries, or other specific interventions related to the individual residents need. Systematic Changes On 05/12/16 the Staff Development Coordinator began in-servicing all current nursing staff (RN, LPN, Medication Aide, Med Tech, CNA both full time and part time regarding the fall prevention. Providing care for residents while in bed to prevent falls • Residents who are unable to assist with bed mobility that also do not have established bed boundaries (such as side rail, bolstered mattress, positioning device, etc.) require 2 persons to assist with the care of the resident while in bed. Positioning a resident too close to the side of the bed and not providing bed boundaries when caring for a resident can place a resident at risk for rolling off the side of the bed. • When providing care to a resident that requires 2 person assistance with bed care, one person must be on each side of the bed at all times. No side of the bed can be left unattended. If one of the care providers must leave the side of the bed then a boundary must be put on that side such as a wedge device. Most common causes of falls • Muscle weakness and walking or gait problems are the most common causes of falls among nursing home residents. Also, a sense of needing to use the toilet can	

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F 323	Continued From page 3 the fall. In an interview on 5/3/16 at 2:00 PM, the treatment nurse stated she and the wound consultant were in Resident #5 ' s room providing wound care on 4/12/16. She stated she rolled Resident #5 onto her right side while she remained on the left side of the bed. She stated the wound consultant left the bedside to document in his computer when Resident #5 ' s slipped out of her hand onto the floor on the right side of the bed. The treatment nurse stated the air mattress may have contributed to Resident #5 rolling out of the bed onto the floor. She stated that now two staff members had to be present with Resident #5 ' s during her wound care. The treatment nurse confirmed Resident #5 was not able to turn herself independently in the bed. In a wound care observation on 5/3/16 at 2:10 PM, the treatment nurse, the MDS nurse and the wound consultant were all present. The treatment nurse raised the bed to the high position in order to perform the wound care. Resident #5 was lying on an air mattress in the middle of the bed. Resident #5 was manually turned onto her left side by the MDS while the treatment nurse and the wound consultant provided wound assessment care on the right side of the bed. Resident #5 had to be held on her left side during her wound care. In an interview on 5/3/15 at 2:20 PM, the wound consultant recalled the fall on Resident #5. He stated he and the treatment nurse stepped away from the bedside for just a second and Resident #5 rolled off the bed onto the floor. In an interview on 5/4/16 at 10:00 AM, Nurse #1 recalled the incident on 4/12/16. Nurse #1 stated she heard the treatment nurse call for help and when she entered the room, she observed Resident #5 ' s lying on the right side of the bed	F 323	be a factor in falls. • Environmental hazards in nursing homes can cause falls such as wet floors, poor lighting, incorrect bed height, and improperly fitted or maintained wheelchairs. • Medications can increase the risk of falls and fall-related injuries. Drugs that affect the central nervous system, such as sedatives and anti-anxiety drugs, are of particular concern. • Other causes of falls include difficulty in moving from one place to another (for example, from the bed to a chair), poor foot care, poorly fitting shoes, and improper or incorrect use of walking aids. • Confusion and dementia can contribute to poor safety awareness and increase risk of falls. What to investigate when a fall occurs? • All falls will be investigated. Staff who was working with the resident at the time of the fall needs to write a statement. The CNA and Nurse who are assigned to the resident at the time of the fall also need to write a statement. All statements should be forwarded to the DON. • Include in the statement: physical surroundings that may have contributed to the fall, any change in the resident before the fall, the last time you saw the resident and what care was provided at that time, any medication changes and any behavior changes to help determine root cause of the fall. Collect your data and document in the incident report. How can we prevent falls in nursing homes?	

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F 323	Continued From page 4 on the floor with a knot on the back of her head that was bleeding. Nurse #1 stated the treatment nurse told her at the time Resident #5 was too close the right side of the bed and when in air mattress adjusted, Resident #5 ' s rolled onto the floor. Nurse #1 stated Resident #5 was not able to move herself independently in bed and it was for that reason she did not require the use of side rails. In an interview on 5/4/16 at 2:00 PM the director of nursing stated the facility treatment nurse did not take her hand off of Resident #5 but acknowledged it was an avoidable fall. In an interview on 5/4/16 at 2:10 PM, the administrator stated Resident #5 ' s fall was avoidable and her expectation was the safety of the residents during the delivery of care.	F 323	Fall interventions include but are not limited to: • Safe positioning: Residents should not be left with the bed in high position and/or in an unsafe position. For example, a total care resident left turned on their side without positioning devices with the bed in high position. • When a resident is on their side receiving care, do not turn your back on the resident. Make sure you have all supplies on hand and easily reached prior to giving care. • Use the over bed table to arrange all needed supplies before starting care. • If you realize an item is missing. Position the resident to a safe position in bed, lower the bed and place the call bell within reach. • When residents are on air mattresses, make sure that you place the mattress in the auto firm setting while providing care. Once care is completed, place the mattress back into the alternate setting. • Always use the number of assistants that the care plan or kardex calls for. • Nurses: if a CNA reports that they need assistance with transferring a resident or with mobility, assistance should be obtained and provided. Teamwork is vital! • If a resident requires assistance with transfers then they should not be left alone in the bathroom. • Residents with the ability to toilet should be checked at least every 2 hours while awake for the need to toilet, especially before meals.	

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F 323	Continued From page 5	F 323	• Call lights should be within reach of the resident and answered promptly. • Frequently used items should be kept within reach of the resident. Such items include: remote for TV, water picture, phone, walker, reacher etc. • Keep the walkway of the resident free from clutter. • Make sure the resident has on shoes and report poor fitting shoes to your nurse. • When poorly fitting equipment is suspected such as walkers, w/c's, etc. report this to the nurse. Nurses can make a referral to therapy as needed. • Residents that become restless may require closer monitoring for a time, resident can be offered activity diversions such as cards, puzzles, coloring, etc. They may need to be placed in areas of greater staff presence such as the nurses' station with an activity, etc. • Report any signs of pain such as moaning, facial grimaces, complaints of pain to the nurse immediately. • Nurses, address pain complaints timely. • Frequent position changes may assist some residents with pain control. • Try to keep noise levels down. If alarms are used, respond quickly. Alarms should not be the first step in falls prevention. • Make sure beds are not left in a high position when leaving the room. • See the resident's kardex or careplan for interventions to minimize the risk of falls. When in doubt, ask your nurse. The Staff Development Coordinator will	

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F 323	Continued From page 6	F 323	ensure that any nurse, CNA, Med Tech or Med Aide who has not received this training by 05/18/16 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Survey Quality Assurance Monitor for monitoring resident's interventions to prevent falls from the bed. This audit will review three new or readmissions and three falls incident reports for the placement of interventions to prevent residents from falling from the bed. This will be completed weekly times 4 weeks then monthly times 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		5/18/16

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F 520	Continued From page 7 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: F520-D Based on staff interview and record review, the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in February 2015 to correct a deficiency at accidents (F323) cited during a compliant survey on 1/12/16. The continued failure of the facility during another Federal survey of record dated 5/4/16 shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: This tags is cross referenced to: F323-D:	F 520	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F520 Corrective Action for Affected Residents Resident # 5 was sent to hospital on 04/12/16 for evaluation post fall. The resident returned to the facility on 04/18/16 following hospitalization for	

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F 520	Continued From page 8 Based on observation, staff interviews and records review, the facility failed to prevent a resident fall by the wound consultant leaving the bedside while the bed was raised in the high position and the resident rolling out of the treatment nurses grasp (Resident 5) resulting in occipital hematoma and laceration for 1 of 3 residents reviewed for accidents. During a complaint investigation on 1/12/16, the facility was cited for F323 for the failing to prevent two resident falls contributed to staff error resulting in injuries of 2 of 3 residents (Resident #4 and Resident #1) reviewed for accidents. In an interview on 5/4/16 at 2:00 PM, the Administrator acknowledged understanding of reciting of F323 during complaint survey of 05/04/16 but stated progress had been made in this area and this situation was a unique one involving an outside provider and the facility treatment nurse.	F 520	Delirium and UTI. The resident's kardex was reviewed and updated by the Interdisciplinary Care Plan Team on 04/18/16. New interventions included two person assistance with care while in bed. Corrective Action for Potentially Affected Residents All residents who are dependent for bed mobility have the potential to be affected by this alleged deficient practice. A new quality assurance process was put in place on 05/17/16 that included assessing all new and readmissions to determine if the resident is in need for additional interventions to prevent them from rolling out of the bed. This will be completed by reviewing the completed risk assessment User Defined Assessment section D for mobility. Residents that are unable to independently assist with bed mobility will be reviewed for additional interventions such as assigning two assistants for bed mobility, adding a grab bar for the resident to hold onto if indicated, adding a bolster or scoop mattress if indicated, adding wedges for boundaries, or other specific interventions related to the individual residents need. Systematic Changes On 05/12/16 the Clinical Nurse Consultant educated the Director of Nurses, Administrator, Staff Development Coordinator, Unit Support Nurse, and MDS Coordinator on the following: • Residents who are unable to assist with bed mobility that also do not have established bed boundaries (such as side rail, bolstered mattress, positioning	

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F 520	Continued From page 9	F 520	device, etc.) require 2 persons to assist with the care of the resident while in bed. Positioning a resident too close to the side of the bed and not providing bed boundaries when caring for a resident can place a resident at risk for rolling off the side of the bed. • When providing care to a resident that requires two person assistance with bed care, one person must be on each side of the bed at all times. No side of the bed can be left unattended. If one of the care providers must leave the side of the bed then a boundary must be put on that side such as a wedge device. • A new quality assurance process was put in place on 05/17/16 that includes the Quality of Life team (Administrator, Director of Nursing, Staff Development Coordinator, Unit Lead Nurse, and MDS Coordinator) assessing all new and readmissions to determine if the resident is in need for additional interventions to prevent them from rolling out of the bed. This will be completed by reviewing the completed admission risk assessment User Defined Assessment section D for mobility. Residents that are unable to assist with bed mobility will be reviewed for additional interventions such as assigning two assistants for bed mobility, adding a grab bar for the resident to hold onto if indicated, adding a bolster or scoop mattress if indicated, adding wedges for boundaries, or other specific interventions related to the individual residents need. Quality Assurance	

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F 520	Continued From page 10	F 520	The Clinical Nurse Consultant will monitor this issue using the Survey Quality Assurance Monitor for monitoring new/readmissions. This audit will review three new or readmissions for the placement of interventions to prevent residents from falling from the bed. This will be completed weekly times 4 weeks then monthly times 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	