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	345537	A. BUILDING _____ B. WING _____	C 06/29/2016

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SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

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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 observations, record review and staff, resident and family interviews, the facility failed to implement fall interventions for a resident (resident #2) with cognitive impairment and to provide supervision to prevent falls for 1 (resident #2) of 3 residents who experienced falls. Findings included: Record review revealed Resident #2 was admitted to the facility on 4/14/2016 with diagnoses which included Vascular Dementia, Osteopenia, Muscle Weakness and Diabetes. The Admission Minimum Data Set (MDS) dated 4/21/2016 indicated Resident #2 was severely cognitively impaired and required extensive assistance with toileting and bed mobility and 1 person assistance for transfers. The Care Plan initiated dated 4/26/2016 listed a focus of potential safety and/or fall risk related to: impaired mobility and dementia with safety impairment. The interventions initiated on 4/26/2016 listed: -Encourage to ask for assistance as needed and respond to call bell as soon as possible -Ensure proper footwear as indicated -Follow facility protocol should a fall occur -Observe for possible medications related causes	F 323	1. Corrective action for resident #2 was unable to be accomplished as resident#2 was discharged on June 19th 2016. 2.All other residents at risk for falls have the potential to be affected by the same alleged deficient practice. Current residents residing in the facility with history of falls in the last 60 days were reviewed to ensure appropriate interventions were implemented. Fall risk assessments were completed on the remaining current residents to identify those at risk for falls. Interventions were implemented. The care plans and Cardexes were updated accordingly. 3.Systemic measures implemented to ensure the same alleged deficient practice does not recur are: The Director of Nursing and Assistant Director of Nursing are re-educating the Licensed Nurses on the “Falls System”. The Director of Nursing and Assistant Director of Nursing are re-educating the	7/27/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/22/2016

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F 323	Continued From page 1 or increased potential for fall -Place call bell within reach at all times -Place items within reach -Provide assistive devices as indicated by therapy skilled services -Refer Physical Therapy/Occupational Therapy services as indicated Revisions were made to the fall risk Care Plan on 6/1/2016 to include: -Provide snacks as indicated -Reorient to environment frequently -Resident education for safety awareness: locking brakes on wheelchair A revision to the falls risk Care Plan was also made on 6/7/2016 for a bed alarm. The goal for the falls risk Care Plan indicated the resident would be free of falls or fall related injury through the next review (target date 7/20/2016). Clinical record review revealed resident #2 sustained 6 falls from 5/17/2016 to 6/18/2016. Incident/accident reports were reviewed for each fall along with the incident/accident investigation follow-up reports. -Fall #1 occurred on 5/17/2016 at 1:00 PM in the 200 hall Dining Room. The facility incident report indicated Nurse #2 witnessed the resident slide from her wheelchair to the floor. The report listed the resident ' s vital signs, no injuries noted and the Physician and the responsible party were notified at 1:30 PM. The report also indicated the intervention for the fall was to add anti-rollback devices to the resident ' s wheelchair and documentation of maintenance adding the devices was attached to the report. -Fall #2 occurred on 5/26/2016 at 4:15 PM in the resident ' s room. The facility incident report indicated Nurse #5 entered resident ' s room and found resident #2 sitting on the floor. Nurse #5 documented in the report the resident attempted	F 323	Certified Nursing Assistants on utilization of the Cardex to determine which fall interventions should be implemented and to ensure they are in use. New admission's fall risk assessments will be reviewed during the morning interdisciplinary team meeting Monday thru Friday to identify residents at risk and review interventions that may need to be implemented. Admissions occurring on the weekend will be reviewed with the Director of Nursing for 30 days and then the RN on call going forward to ensure if resident is identified at risk for falls interventions are implemented. Any resident who sustains a fall will also be reviewed during the interdisciplinary team meeting Monday through Friday to ensure appropriate interventions have been implemented. Residents who fall over the weekend will be reviewed by calling the Director of Nursing for 30days. After 30 days the Registered Nurse on call will be notified to ensure the appropriate intervention has been implemented. Care Plans and Cardexes will be up-dated as interventions are added or discontinued by the Director of Nursing, Assistant Director of Nursing, Resident Care Management Director or Minimum Data Set Nurse to reflect the current fall interventions. 4. Facility Ambassadors will audit fall interventions Monday through Friday using the Cardex to validate interventions are in place and the Weekend Manager on Duty and Charge Nurses will audit the weekends. The audits will be completed daily times 1 week and weekly times 3	

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F 323	Continued From page 2 to get out of the wheelchair without locking the chair and fell to the floor. The report listed the resident ' s vital signs, no injuries noted and the Physician and the responsible party were notified. The report listed fall interventions were non-skid socks and resident education. The report also indicated the resident verbalized understanding. -Fall #3 occurred on 5/29/2016 at 4:45 PM in the resident ' s room. The facility incident report indicated Nurse # 6 was called to the resident ' s room by NA #1 and the resident was noted to be on her knees and holding on to the roommate ' s nightstand. Nurse # 6 documented the resident stated she was looking for food. The report included the resident ' s vital signs, no injuries noted and the Physician and the responsible party notification. Vascular Dementia was listed as diagnosis which contributed to incident. The report listed fall interventions were reorientation for resident to environment with understanding noted and meal provided with 100% consumed. A nursing note dated 5/30 at 1:14 PM indicated the resident was complaining of left arm, left shoulder, and left wrist pain. The resident ' s daughter was in the room visiting. The note reported the resident was unable to express the intensity of pain due to confusion. An order for x-rays of Left arm, shoulder, and wrist with 2 views to rule out fracture was obtained and a portable x-ray was obtained. A nursing note dated 5/30/2016 at 4:30 PM indicated x-rays were negative for fractures and physician and family were notified. The note further reported the resident was abducting (movement up to shoulder or higher) and adducting (movement down to side of body) left arm without difficulty with no verbal or non-verbal indications of pain. A nursing note dated 5/30/2016 at 6:49 PM indicated a hard copy of the x-ray report was	F 323	and then monthly times 2. Random weekly audits will be conducted on going. Results of the daily audits will be discussed Monday through Friday and then weekly during the Interdisciplinary Team Meeting for 4 weeks. Negative findings will be corrected if noted. Results of all audits will be taken through the monthly Quality Assurance Performance Improvement meeting times 3 months. If the Quality Assurance Performance Improvement Committee identifies any negative trends, additional interventions will be implemented and monitored by the Committee.	

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obtained and revealed a subtle fracture of the humeral neck (upper arm just below shoulder) without displacement. Physician notified and ordered to send resident to the Emergency Department (ED) for evaluation and treatment. The note reported the resident continued to have no report of pain and no edema was noted.
Nursing note dated 5/30/2106 at 8:27 PM indicated the resident returned to facility with a sling to left arm, orders to make a follow up appointment with an orthopedic physician and orders for pain medication as needed. The appointment was scheduled for 6/14/2016.
An Occupational Therapist (OT) clinical note dated 6/1/2016 at 2:26 PM reported resident was assessed by OT per ED recommendation. No splint was indicated and resident was to continue with sling until appointment with orthopedics.
-Fall #4 occurred on 6/4/2016 at 6:20 AM in the resident ' s room. Review of facility incident report stated resident was found on the floor by NA #2 beside her bed. Nurse # 1 documented in the facility incident report the resident stated she was getting out of bed to go to the bathroom and fell and did not call for assistance. The resident sustained 2 skin tears to the left arm. The report included the resident ' s vital signs, the skin tears, and the Physician and the responsible party notification. Dementia was listed as diagnosis which contributed to incident. The report listed fall interventions as first aid to the skin tears and a bed alarm.
Clinical notes indicated the resident was transferred to an orthopedic appointment on 6/14/2016 and returned to the facility with orders for passive range of motion for the left shoulder per Physical Therapy 3 times a week and no movement of left shoulder over shoulder level unless working with PT. No indication for follow

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up appointment was listed.
-Fall #5 occurred 6/18/2016 at 2:30 AM in the resident ' s room. Nurse #1 documented in the facility incident report the resident was found on the floor by NA #2 beside her bed after attempting an unassisted transfer to bathroom. The resident sustained a bruise and a quarter sized hematoma to the back of the head. The Physician Assistant was notified. Ice packs to head and neuro-checks initiated. The report included the resident ' s vital signs, the injury and the Physician and the responsible party notification. Dementia was listed as diagnosis which contributed to incident. The report listed interventions were resident was assisted to the bathroom, redirected, and lights dimmed.

-Fall #6 occurred 6/18/2018 at 3:30PM in the resident ' s room. Nurse # 4 documented in the facility incident report the resident was found sitting on her buttocks on the floor beside her bed. Nurse #4 documented the resident had no injuries and the resident denied pain. The report included the resident ' s vital signs, the outcome of no apparent injuries, and the Physician and the responsible party notification.
Dementia was listed as diagnosis which contributed to incident. The follow up report to the incident reported the resident was sent to the Emergency Department for evaluation and increased falls. Review of the facility physician orders dated 6/18/2016 at 11:30 AM (date error on order discovered upon interview with Nurse #5, order was actually written on 6/19/2016) to send resident to ED for evaluation and treatment of left hip and left wrist pain status post fall. Hospital records were obtained and reviewed. The resident was admitted to the hospital on 6/19/2016 with Diabetic Ketoacidosis, Vascular

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Dementia and Pelvis Fracture. The x-ray final result dated 6/19/2016 at 3:43 PM reported: Findings: Osteopenia, Degenerative changes, Irregularity along the right superior pubic ramus (part of the pubic bone) concerning for fracture. Degenerative changes in the hips.
Impression: Subtle fracture suspected in the right superior pubic ramus. The expected correlate in the superior ramus is difficult to identify.
Resident was discharged to home on 6/24/2016.
A telephone interview was conducted with a family member on 6/28/2016 at 9:10 AM. The family member expressed concern with the number of falls the resident sustained while at the facility. The family member stated she had voiced her concerns to some of the nurses and did not understand why fall interventions were not implemented, especially since the resident had issues with cognition. The family member reported there was no fall mat and she had requested one several times. The family member also reported the bed alarm was not applied until she stood at the nurse ' s station one weekend and told the nurse she was not leaving until an alarm was put on the bed. The family member expressed concern over being told by several nurses the resident needed to use the call light to call for assistance. The family member stated the staff knew the resident ' s cognitive deficits and the resident could not call for assist. The family member stated the resident had sustained a pelvic fracture from the last fall and she informed the hospital she refused for the resident to be sent back to the facility.
A telephone interview with Nurse #1 on 6/28/2016 at 10:20 AM revealed Nurse #1 was working with the resident on the day of fall # 4 and fall #5. Nurse #1 recalled the falls and reported she asked the resident several times why she didn ' t

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call for help and the resident would get angry. Nurse #1 reported the resident sustained skin tears during the one of the falls and sustained a knot on her head on the last fall. Nurse #1 was unsure of the fall interventions for either of the falls. Nurse #1 indicated the resident did not have a bed alarm and Nurse #1 had no recollection of applying an alarm. Nurse #1 indicated if it was written on the incident report to apply bed alarm it was the nurse who completed the reports ' responsibility to apply the alarm. Nurse #1 reported the resident was not oriented and was unable to follow directions.

An interview was conducted with Nurse #2 on 6/28/2016 at 11:00 AM. Nurse #2 reported witnessing fall #1 in the 200 hall dining room. Nurse #1 stated the resident slid from the wheelchair to the floor. Nurse #1 stated the resident was not oriented and was unable to follow directions. Nurse #1 could not recall if any fall interventions were in place.

An interview was conducted with NA#2 on 6/28/2016 at 1:00 PM. NA #2 worked with the resident when fall #4 and fall #5 occurred. NA #2 recalled both falls and reported he was doing rounds and saw the resident on the floor beside the bed both times. NA #2 indicated a bed alarm was on the bed for the fall that the resident bumped her head (fall #5) because it was reattached after the resident was toileted. NA #2 stated the alarm was functioning when it was reattached but could not recall if it was prior. NA # 2 did not recall much about the fall #4 with the exception of the fall was from the bed. NA #2 reported the resident was confused and would try to get up unassisted. NA #2 had no recollection of the resident ever using the call light and stated the resident did not understand to call when assistance was needed.

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An interview was conducted with nurse #6 on 6/28/2016 at 2:30 PM. Nurse #6 worked with resident when fall #3 occurred. Nurse # 6 did not recall much about the incident other than NA #1 called her to the room, resident was on her knees and resident reported looking for food. Nurse # 6 indicated the resident was confused and not easy to redirect.
An interview was conducted with NA #1 on 6/28/2016 at 3:40 PM. NA #1 worked with resident when fall # 3 occurred. NA #1 indicated the resident had a bed alarm but did not recall if it was sounding. NA #1 remembered the resident indicated hunger and NA #1 went to the kitchen and got the resident ' s dinner tray and assisted with the meal. NA #1 stated the resident was confused and pleasant at times but did not understand to call for assist even if you reminded the resident often.
An interview was conducted with Nurse #4 on 6/29/2016 at 9:22 AM. Nurse #4 indicated she worked with the resident the evening of fall #6. Nurse #4 stated the resident was found by NA #1 sitting on her buttocks beside the bed. The resident had no complaints of pain, was assessed and placed in her wheelchair at the nurse ' s station. Nurse #4 reported the resident was taken to Restorative Dining for supper and then placed in bed later in the evening. Nurse #4 recalled the resident complained of left shoulder pain, was medicated and reported no further complaints. Nurse #4 also worked the night shift and reported the resident rested with no complaints. Nurse #4 reported she worked weekends only and recalled a bed alarm was applied the prior weekend. Nurse #4 stated a family member came to the nursing station the weekend before and requested a bed alarm due to the resident ' s falls. Nurse #4 recalled getting

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the bed alarm and the family member was in the resident ' s room when it was applied to the bed. Nurse #4 revealed the family member expressed concern about the resident ' s safety due to repeated falls and expected the facility to provide some type of fall interventions.
A telephone interview was conducted with Nurse #5 on 6/29/2016 at 12:30 PM. Nurse #5 indicated information was received in morning report of resident ' s fall during the prior evening shift. The resident had no complaints during morning rounds. Nurse #5 did not recall any issues with the resident until morning care when the resident complained of left hip and left wrist pain. Upon assessment Nurse #5 noted the resident ' s left hip to be slightly swollen and tender to touch. A telephone order to send the resident to the ED for evaluation was obtained and the resident left the facility by Emergency Medical Services around noon. Nurse #5 indicated a call was made to the family member to inform of the resident ' s condition and transport.
In an interview with the Physical Therapist (PT) and Occupational Therapist (OT) on 6/29/2016 at noon, both reported the resident was ordered therapy on admission. PT revealed difficulty in determining the resident ' s needs due to inaccuracy of resident ' s responses. Resident required maximum cues for any task. PT indicated the resident had extremely poor safety awareness and was a definite falls risk. PT reported the resident ' s cognition due to the dementia made any task difficult. OT reported the resident required maximum cues for any tasks and oftentimes was unable to follow through with directions. OT reported the resident was assessed after the shoulder fracture for proper sling placement and staff was educated on application of the sling. OT and PT reported no

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observed issues with the sling. The PT reported the resident had orders from the orthopedic physician visit on 6/14/2016 for therapy but the resident was discharged to the hospital on 6/18/16 and that was the date the resident was on the therapy caseload schedule.
An interview with the Administrator on 6/29/2016 at 2:15 PM revealed all falls are reviewed in the daily clinical meetings and the interventions are reviewed. The Administrator stated recollection of a bed alarm and a fall mat for the resident. The Administrator stated she was not sure when either had been applied and it is the responsibility of the staff that initiates fall interventions to follow through with the interventions. The Administrator indicated there was no system to ensure the interventions were completed. The Administrator stated awareness of the frequent falls and indicated the plan was to place the resident on 1:1 supervision upon return from the hospital but did not get the opportunity. The Administrator stated her expectation was for fall interventions to be appropriate and individualized for each resident ' s needs.
An interview with the DON on 6/29/2016 at 2:15 PM revealed falls are reviewed in the daily clinical meetings. The DON stated awareness of the frequent falls and agreed with the interventions that were implemented for the resident and felt the interventions were appropriate for the resident. The DON stated her expectation was for fall interventions to be appropriate and individualized for each resident ' s needs.