STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 03/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interview, physician interview and record review the facility failed to assess a resident for fall related injuries, failed to observe the scene of the fall to gather information for fall prevention/fall risk reduction, prior to the resident being transferred from the floor to the bed, for 1 of 3 sampled residents (Resident #2): The findings included: Resident #2 was admitted 3/3/17 with diagnoses	F 323	Resident #2 was alert and oriented. The nurse observed the resident in bed following the fall on 3/11/17, and resident did not voice any complaints of pain at that time. Resident was assessed again on 3/12 with no complaints of pain and no evidence of injury. On 3/13 resident was noted to have bruising on left side of body but no complaints of pain or discomfort. Later during the day on 3/13 while working	4/22/17

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

Electronically Signed | 04/13/2017

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F 323	Continued From page 1 including cerebral infarction, monoplegia of upper limb (unspecified side), chronic obstructive pulmonary disease, Type 2 diabetes mellitus, heart failure and hypertension. The Admission Minimum Data Set (MDS) dated 3/10/17 revealed Resident #2 was moderately cognitively impaired and required extensive assistance of 1 person for transfers, was not steady but could stabilize with assistance and had upper and lower limb impairment on one side. It also revealed that he was 74 inches tall (6 feet 1 inch) and 220 pounds. Review of the Care Plan revealed therapy goals dated 3/3/17. There was no other care plan content that was dated prior to the resident ' s discharge on 3/13/17. The Physician ' s Orders dated 3/3/17 revealed as order for Coumadin (an anticoagulant / blood thinner medication) 5 mg (milligrams) once a day and an order for PT/INR (prothrombin time/international normalized ratio - a blood test used to monitor for correct dosage of medications like Coumadin and to detect high risk of bleeding problems) lab work on 3/6/17. Further review of the Physicians orders from 3/3/17 - 3/13/17 revealed the dosage of the Coumadin remained the same throughout the residents stay. Review of the Nursing Admission Assessment dated 3/3/17 revealed Resident #2 had left sided weakness. The assessment of his skin condition indicated he had "red and dark bruises to bilateral arms." No other bruising was noted in the assessment. On 3/4/17 a Fall Risk Prevention assessment was completed. It indicated Resident #2 was at	F 323	with therapy resident had decrease level of consciousness and an order was obtained to send resident to the hospital. Current facility residents have the potential to be affected by this practice. The Region Clinical Director and the Director of Nursing began in-service education on 3/27/2017 regarding facility protocol to include , assessment prior to moving resident unless emergency situation, observation of scene and data collection related to incident to assist with determining root cause of incident and timely documentation to include actual time and date of incident. The floor nurse/Director of Nursing has been educated on completing post fall assessments and investigation on 3/27/2017 by the Region Director of Clinical Services of the North. The Region Clinical Director and the Director of Nursing began in-service education on 3/27/2017 for the licensed nurses and nursing assistants including part time and PRN staff, regarding facility protocol to include assessment prior to moving resident unless emergency situation, observation of scene and data collection related to the incident to assist with determining root cause of incident and timely documentation to include actual time and date of incident. Education will be completed by 4/22/17. The in service education will be provided during new hire orientation for licensed nurses and nursing assistants. The Administrator and the Director of Nursing will review incident	

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F 323	Continued From page 2 high risk for falls. Review of the PT (Physical Therapy) Daily Treatment Notes from 3/3/17 - 3/12/17 revealed the resident needed Min(A)-CGA (minimum assist-contact guard assist) to prevent left knee buckling on standing. The notes indicated the resident was instructed that he should turn towards his left side when transferring. Review of the Lab Report for PT/INR dated 3/6/17 revealed a hand written note indicating that the Coumadin should continue at 5 mg and the PT/INR should be rechecked in 1 week (on 3/13/17). Review of the Progress Notes revealed a Late Note entry made on 3/12/17 at 3:00 PM "CNA (Nursing Assistant) reports that she transported this resident to bedside commode without incident. When he was finished and ready to go back to bed he was unable to transfer with her assistance. CNA assisted him to a seated position and came and asked for assistance. Second CNA helped her get resident back to bed. Nurse entered the room and ask (sic) resident if he was alright. Resident said yes, and didn ' t voice any concerns at the time to the nurse. Resident was in bed with call bell in reach, in no acute distress." Interview with the Director of Nursing (DON) on 3/25/17 at 2:00 PM revealed the fall incident occurred on 3/11/17, not on 3/12/17. This was verified with the Administrator post survey exit. Further review for the Progress Notes for 3/11/17 through the resident's discharge on 3/13/17 revealed no documentation of a post fall physical assessment, or post fall vital signs, and no documentation of any post fall follow-up	F 323	reports daily at least 5 times a week, ongoing to validate post-fall physical assessment, scene observation and data collection, documentation that includes the physical assessment and data collection information and appropriate interventions have been implemented. Monthly for a minimum of three months, the Administrator and Director of Nursing will report the findings of the audits to the Quality Assurance Committee. The Quality Assurance Committee will review the audit to make recommendations to ensure compliance is sustained on going to determine the need for further audits beyond three months.	

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assessments.

A 3/13/17 Progress Note at 1:03 AM revealed that Resident #2 "multiple bruises along left side of body res (resident) is on blood thinners and is easily bruised and also was lowered to the floor by CNA yesterday". As noted above, the fall referenced in this note occurred 3/11/17. Further review of the note revealed that a family member had visited earlier and "believes this is where the bruises came from, no evidence or c/o (complaints) pain."
Review of the Physical Therapy Note dated 3/13/17 at 4:50 PM revealed "Pt (patient) c/o feeling ' like I ' m gonna pass out ' then was unresponsive after < 1 (less than) minute. Nurse called to pt ' s room. Pt transferred with 4 person assist d/t (due to) pt completely unresponsive and sliding out of w/c. Pt then sent out to ER for further eval (evaluation)."

On 3/13/17 a Progress Note at 11:50 PM revealed "at about 4:30 PT got resident out of bed to w/c to work with him and he had an episode of decreased LOC "level of consciousness" and some jerking was noted. Order obtained to send to ER (Emergency Room) for further evaluation and treatment."

A typed, unsigned, statement dated 3/25/17 at 1:24 PM by Nursing Assistant #1 (an Agency Nursing Assistant) (NA #1) in regards to Resident #2 ' s fall incident on 3/11/17 revealed "I was told to go in there because he needed to changed. He stated that he could not pee in his brief he wanted to go to the bathroom. I said not a problem, and pulled his wheel chair next to his bed and we did a stand and pivot. He wanted to go into the bathroom. I did not know how the

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bathroom was shaped and so I explained to him it was not enough room for us to do a transfer from the wheelchair to the toilet safely. He had a bedside toilet there so he stated he would use that. So I pulled the toilet out and wheel chair beside and we completed another stand and pivot to the toilet. He was on the toilet about 45 seconds, I took my gloves off to give him privacy and to leave the room but he stated he was finished. So I pulled his chair back up so we can do the same stand and pivot, the chair was lock when we went to do the stand and pivot. He started to slide out of the chair. So I am holding him at the same and he was sliding so I helped him to the floor. I went and got the Nurse to ask for assistance in getting him off the floor, and she stated "I just hurt my back, so I can ' t help you but when the other gentleman returned, he helped me get (name of Resident #2) into the chair and we made sure he was dry. Nurse never entered into the room to check on him again to my knowledge. I checked on him two more times during my shift. I changed him at 10:45 PM and I asked him again if he was in any pain. He stated no and assisted me with rolling over in the bed."

On 3/25/17 at 3:15 PM the Director of Nursing (DON) provided the typed statement from NA#1 (see above). During interview at this time the DON revealed that she was working as the hall nurse for Resident #2 on the day of his fall. In reference to NA#1 ' s statement that the Nurse did not go in the room after the resident fell, the DON acknoledged that she, as the hall Nurse, did not go in the room at that time. The DON said that NA#2 was close by when NA #1 asked for help, so she sent NA #2 to help NA #1 get the resident up off the floor. She stated that her reason for not going in the room to see Resident

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#2 at that time was because she wanted to go in later when NA #1 wasn ' t there, so that Resident #2 would feel free to speak up it he felt that NA #1 had done something wrong. The DON said that when she did go in the room to see Resident #2, he told her he did not fall; he just sat down on the floor. She said he also denied having pain. The DON added that she also asked NA #2 if Resident #2 had been sitting or lying on the floor and NA #2 said he had been sitting.

On 3/25/17 at 3:43 PM, interview with NA #2 revealed that he was working on the Resident #2 ' s hall on the 3:00 PM - 11:00 PM shift the day the resident fell (3/11/17). He stated that he thought it was NA #1 who came and got him and said "I have one on the floor, I need help." Then he said "she probably told (name of the DON) first then went and found me, I was on the way." When asked to clarify he stated "I remember NA #1 telling me first; no I don ' t really remember who did". NA #2 stated that the incident occurred after dinner, possibly close to 7:00 PM. What he saw when he entered the room was Resident #2 sitting on the floor beside the commode right beside his bed, he did not notice the location of the wheelchair. The NA said he did not recall anything NA #1 told him about the incident he just remembered them getting the resident back into bed. He stated that it was somewhat difficult to get Resident #2 up off the floor because he was pretty heavy. He indicated that NA #1 was on one side of the resident and he was on the other side; they both held Resident #2 by hooking one of their arms under his arm then using their other hand to holding onto his sweat pants and hoist him up. He said they did not use a gait belt at that time. NA #1 also said that no one had previously asked him to describe what he

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observed or what happened after the resident's fall.

On 3/25/17 at 5:33 PM during telephone interview with the Physician he stated that he did recall being notified of the fall but it was his understanding the resident was just lowered to the floor. He acknowledged that lowering someone to the floor was considered a fall but said that he trusted the judgment of the staff that it was not a serious incident. He also said that a couple of days later he recalled being notified that the resident was unresponsive. He stated that he had been unaware of the bruising that was identified the day after the fall on 3/12/17 but noted that the Residents INR result was within an acceptable therapeutic range. The Physician stated that even though the resident was on Coumadin he would not be concerned about bruises that were documented as "multiple bruises along left side of body" unless there was pain and/or a loss of function; so he would not have expected to be notified of these bruises. He acknowledged that the bruises could have occurred as a result of the fall or during the efforts to get the resident up but added that there was no way to know for sure.

On 3/25/17 at 6:00 PM during interview with the Administrator she acknowledged that she could not locate any evidence of Resident #2 being assessed by a Nurse immediately post his fall and prior to being returned to bed. She also indicated that she was aware that an immediate post fall assessment for injury should be completed. The Administrator was also unable to provide any information about the scene of the fall, or an investigation of the fall, completed by the facility pre survey entry.

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