STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	523 COUNTRY CLUB 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=G	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 observation, record review, resident interviews, family interviews and staff interviews for one (Resident # 1) out of three sampled residents with a history of falls, the facility failed to assure a nurse aide followed facility fall prevention training to prevent injuries. The findings included: Record review revealed Resident # 1 was admitted to the facility on 1/7/16. The resident	F 323	Past noncompliance: no plan of correction required.	5/24/17

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

Electronically Signed | 05/24/2017

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had diagnoses of dementia, diabetes, hypertension, anemia, congestive heart failure, coronary heart disease, history of renal cell carcinoma, and a loss of her right eyesight. Review of the resident's medical record revealed she had sustained multiple falls prior to residing at the facility, and had sustained fractures of both her humerus bone and her lumbar spine.

Review of the resident's quarterly MDS (Minimum Data Set) assessment, dated 2/7/17, revealed the resident was severely cognitively impaired. The MDS also coded the resident as having impaired vision and the need for two staff members to assist for transfers.

Review of the resident's care plan revealed the staff identified on the resident's care plan on 1/14/16 that Resident # 1 was at risk for falls. A problem was entered on this care plan as, "(Resident # 1) is at risk for falls r/t (related to) her impaired mobility, dependence on staff, restless behavior/poor safety awareness, use of diuretics, narcotic analgesics and overall compromised health status." There were multiple interventions added to the care plan to address the resident's risk for falls. One of these interventions was that she required two staff members to assist with transfers.

Review of nursing notes revealed an entry on 4/20/17 at 7:46 PM by Nurse # 1 noting that the resident had been found on the bathroom floor at 5:30 PM with her brief and pants lowered around her thighs.

Review of x-ray reports, dated 4/20/17 and 4/25/17, revealed the resident was identified to have fractures of the 4th, 5th, 6th, 7th, and 8th

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ribs following this incident.

Interview with the Administrator and DON (Director of Nursing) on 5/16/17 at 12:45 PM and again at 4:55 PM revealed the following information. The facility had conducted an investigation into the incident and found Nurse Aide (NA) #1, who had been involved in the incident, had ignored her facility training by transferring the resident without assistance and by leaving the resident unattended while in the bathroom. According to the DON and Administrator the facility provided training upon orientation to every nursing staff member in regards to the facility's fall prevention program, and continued to provide ongoing training even after employment. The Administrator and DON provided documentation verifying that NA # 1 had received training on multiple occasions regarding fall prevention policies in the facility. The DON and Administrator provided the content material which was covered within their program. The program material included information to staff that residents with dementia and with a history of previous falls were considered high risk for future falls. It also included the information that residents, who were at high risk, were to never be left in the bathroom alone. Within the fall prevention program staff were directed to be aware of residents' care plans and the kardex (care guide). According to the DON and Administrator, on the evening of the accident, NA # 1 had assisted Resident # 1 by herself to the bathroom around dinner time. The Administrator and DON stated the resident at times needed a longer time in the bathroom and NA # 1 had stayed with her for a time period when she heard the announcement that dinner trays were on the hall. The Administrator and DON stated NA # 1

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then left the resident to go and start delivering dinner trays, and checked on her in between passing trays. According to the Administrator and DON, staff were trained that all residents are considered at risk for falls due to the fact that they are not in their home environment. The Administrator and DON stated for more than a year there had been signs in all residents' bathrooms directing staff that a resident should never be left unattended on the toilet. The DON stated NA # 1 acknowledged she saw the sign, but still decided to go and deliver the dinner trays. The DON and Administrator stated on the evening of the incident, another NA heard the resident calling and discovered her on the bathroom floor.

NA # 1 was interviewed on 5/16/17 at 2:15 PM. NA # 1 stated on the evening of the incident she had not checked the resident's kardex before her shift. She stated she had cared for Resident #1 before. She stated the medication aide told her around dinner time that Resident # 1 needed to go to the bathroom, and she assisted her onto the toilet without getting assistance from another staff member. The NA stated she stayed with her for about five minutes before hearing the announcement that dinner trays were on the hall. NA # 1 stated she told Resident # 1 she was going to check on the dinner trays and she would be right back. She said the resident responded, "Okay." NA # 1 stated she went across the hall and delivered one tray and returned to find Resident # 1 still was not done. NA # 1 stated she told her again she would be back and went to deliver another tray. The NA stated before she could return from delivering this tray, another NA came to her and told her Resident # 1 was on the floor. The NA stated she had not thought

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Resident # 1 would try to stand up while she was gone.

On 5/16/17 at 3:45 PM it was observed that there was a visible sign in the resident's bathroom located above the toilet that read, "Do not leave resident unattended on toilet." Resident # 1's responsible party and a family member of Resident # 1's roommate were present at this time. Both of these family members stated the sign had been present prior to Resident # 1's fall on 4/20/17.

Nurse Aide # 2 was interviewed on 5/16/17 at 4:06 PM. The NA stated she had been employed by the facility for two years and the signs to not leave residents in the bathroom unattended had always been there during that time. The NA stated she was taught this during her initial orientation at the facility.

NA # 3 was interviewed on 5/16/17 at 4:15 PM and stated she had been employed for three years. NA # 3 stated she had been taught not to leave a resident unattended on the toilet in the bathroom.

NA # 4 was interviewed on 5/16/17 at 4:20 PM. The NA stated she had been employed for two years, and as long as she could recall there had always been signs in residents' bathrooms to not leave residents unattended on the toilet. The NA stated she had also received training regarding resident safety on orientation and throughout her employment at intervals.

Interview with the Administrator and DON on 5/16/17 at 12:45 PM and again at 4:55 PM revealed they had addressed the incident within

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their quality assurance program and had initiated a plan of correction starting 4/21/17 and completed in-services and audits by 5/8/17. Specifically the Administrator and DON provided documentation the following measures were taken. In regards to Resident # 1 the resident was evaluated by the NP (nurse practitioner) on 4/21/17 and 4/24/17, and also evaluated by the physician on 4/24/17 and 4/27/17. Both the NP and physician provided orders to address the resident's pain management and measures to prevent respiratory complications following the rib fractures. On 4/21/17 a physical therapy evaluation was conducted to determine the resident's transfer status during the healing process. The facility met with the resident's family on 4/21/17 to discuss the incident. They had evidence of a thorough investigation into the incident. They provided evidence an initial report was filed within 24 hours and a final report within five days to the state health care personnel investigations regarding the incident. On 4/21/17 they confirmed Resident # 1's transfer status was correct within the Kardex system and the care plan. They placed on Resident # 1's Kardex and care plan not to leave her unattended on the toilet. They provided evidence they had identified other residents at risk for similar accidents. On 4/21/17 they began reviewing 100% of their residents' Kardex and care plans to assure accuracy. This was completed by 5/2/17. They reviewed nursing staff files to determine if each employee had a skills checklist completed within the past year, and for those who had none within the past year, they required the checklist to be completed by 5/8/17. Regarding measures to prevent the reoccurrence they did the following. Within their review of the Kardex system, they placed each resident's cognitive status on the

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Kardex information to alert staff to the severely cognitively impaired residents. The Administrator and DON stated they still continued their policy that no residents should be left unattended in the bathroom, but they also reinstated their "fall leaf" program to alert staff to those residents who had greater risk factors. This information was included on the Kardex. They re-inserviced their staff on transfers, fall prevention, and accessing the Kardex/care plan system. The inservices were completed on 4/26/17. Through audits, they required all of their NAs to show they could access the Kardex system correctly and transfer the resident per the resident's plan of care which was on the Kardex. Audits were completed on 4/29/17. The facility planned to continue the transfer audits weekly and the findings were to be discussed within clinical meetings. Ten percent of their residents were to be audited weekly on an ongoing basis to assure care was being provided by the Kardex system/care plan. Any non-compliance issues identified in their audits were to be discussed on an ongoing basis within their quality assurance monthly program.

The following measures were taken to verify the facility's implementation of their correction plans. Interviews were conducted with nurse aides during the complaint investigation, and the nurse aides were able to validate they were knowledgeable regarding fall prevention policies of the facility and where to access residents' care plan information. Other residents, who had sustained falls since Resident # 1's incident, were reviewed and these reviews did not reveal deficient practice in regards to the facility's fall prevention program.