STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 2-25-2019 through 2-28-2019. the facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness, Event ID# 1C0P11.	E 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		3/6/19

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

Electronically Signed | 03/13/2019

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F 656	Continued From page 1 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement a resident ' s care plan by failing to have two staff assist when providing care and repositioning a resident in bed for 1 of 29 sampled residents reviewed (Resident # 12). The findings included: Resident # 12 was initially admitted to the facility on 9/27/11 with diagnoses of Cerebral Infarction with right sided Hemiplegia, Aphasia, Convulsions and Dementia. Review of the most recent quarterly Minimum Data Set (MDS) completed on 11/22/18 revealed that Resident # 12 had short and long term memory problems and severely cognitively impaired for making daily decisions. Resident # 12 was totally dependent on staff and required 2 person physical assistance with bed mobility, transfers, and toilet use. Review of a care plan initiated on 4/7/14 and in was place on 11/29/18 read in part, Resident # 12 was dependent on staff for activities of living (ADL) care (bathing, grooming, dressing, bed mobility, transfer, locomotion, toileting) due to	F 656	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F656 Resident # 12 was assisted by one staff member, when it should have been two, with bed mobility/care that resulted in resident falling from bed and an injury. As indicated in the citation, the Care Plan was in place but the staff member failed to request assistance when providing care to Resident #12. NA # 1 was placed on suspension 11/27/18 while the incident was being investigated to prevent any	

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F 656	Continued From page 2 chronic disease status post cerebral vascular accident (CVA) compromising functional ability. The interventions included the resident was totally dependent on staff and required 2 person assistance with bed mobility, transfers, and toilet use. Review of the X-ray completed on 11/29/18 revealed Resident # 12 had a right distal femur fracture. An interview was conducted with the RN Unit Manager on 2/26/19 at 2:55 PM. The RN Unit Manager stated Nurse # 1 came and reported to her Resident # 12 had fallen and she was going to send her out to the ER. She stated Nurse # 1 reported to her that the Nurse Aide was in the room alone, providing care when Resident # 12 fell out of the bed. The RN Manager stated that Resident # 12 was flaccid on her right side and needed 2 person assistance with bed mobility and bathing. Nurse # 1 stated she asked the NA if she attempted to get someone to help her give care, and NA # 1 stated that she did not ask anyone to help her with Resident # 12. An interview was conducted with the Director of Nursing (DON) on 2/26/19 at 1:43 PM she stated there was one NA providing care when Resident # 12 fell out of bed. The DON stated the NA was suspended pending their investigation and later terminated. On 2/26/19 at 3:46 PM a telephone interview was attempted with NA # 1, who was providing care for Resident # 12 when she fell from bed on 11/29/18, but her telephone number was no longer in service.	F 656	further injuries to other patients by failing to follow the Care Plan Directives. NA #1 was terminated effective 11/27/18 when the investigation revealed she was aware of the Care Plan for resident #12 but failed to follow proper protocols. Other residents identified as requiring two-person assist with ADL Care could have been affected by the actions of NA #1. Staff received education about the need to provide care in accordance with the Resident Care Plan on 11/29/18. 100% audit was completed on 2/27/19 by the Unit Managers regarding resident transfer/bed mobility assessments to ensure accurate, and on the nurse aid Kardex appropriately. Any deviations were corrected immediately. Nursing Leadership (Director of Nursing, Assistant Director of Nursing, Nurse Educator and Supervisors) Educated staff on 2/27/19 regarding the process for of Safe Resident Handling to include appropriate numbers of staff utilized for bed mobility and transfers based on Lift Assessments and plan of care, the process for ensuring that any question of equipment operability should be referred to Maintenance for evaluation, proper positioning for bed mobility and transfers, Furthermore, staff were educated that failing to use the appropriate number of staff for bed mobility and transfers would be treated as neglect of resident safety. Education included Full time/Part time/PRN and Agency staff members.	

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F 656	Continued From page 3	F 656	Nursing Supervisors, Charge Nurses and the Nurse Practice Educator (NPE) will periodically monitor staff activity during the provision of care and any deficient practices will be referred to the NPE for additional education. Appropriate number of staff needed for bed mobility will be added to Resident Care Cards and Care Plans for staff reference. Five random audits will be conducted each week to assure appropriate procedures are followed for bed mobility and transfers according to the Plan of Care and Assessment. Facility will continue to discuss any falls from the previous day to determine cause and to assure proper interventions are in place. Falls will continue to be reviewed as Adverse Events at the monthly QAPI meetings. Necessary action plans and education will be provided to staff as indicated. Director of Nursing is responsible for the implementation of this plan.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		3/6/19

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F 689	Continued From page 4 Based on record review and staff interviews the facility failed to have two staff assist when providing care and repositioning a resident in bed to prevent the resident from falling from bed and sustaining an injury for 1 of 4 residents sampled for accidents (Resident # 12). Resident # 12 fell from bed during incontinent care and sustained a right distal femur fracture that required an immobilizer. The findings included: Resident # 12 was initially admitted to the facility on 9/27/11 with diagnoses of Cerebral Infarction with right sided Hemiplegia, Aphasia, Convulsions and Dementia. Review of a care plan initiated on 4/7/14 and in place on 11/29/18 read in part, Resident # 12 is dependent for activities of living (ADL) care in (bathing, grooming, dressing, bed mobility, transfer, locomotion, toileting) due to chronic disease status post cerebral vascular accident (CVA) compromising functional ability. The interventions included the resident required total dependence with 2 person assistance with bed mobility, transfers, and toilet use. Review of a care plan initiated on 4/7/14 and in place on 11/19/18 read in part, Resident # 12 is at risk for falls due to CVA with hemiplegia, cognitive loss and no safety awareness. Review of a nursing assessment dated 11/21/18 revealed that Resident # 12 was at moderate risk for falls. Review of the most recent quarterly Minimum Data Set (MDS) completed on 11/22/18 revealed that Resident # 12 had short and long term	F 689	F689 Resident # 12 was assisted by one staff member, when it should have been two, with bed mobility/care that resulted in resident falling from bed and an injury. As indicated in the citation, the Care Plan was in place but the staff member failed to request assistance when providing care to Resident #12. NA # 1 was placed on suspension 11/27/18 while the incident was being investigated to prevent any further injuries to other patients by failing to follow the Care Plan Directives. NA #1 was terminated effective 11/27/18 when the investigation revealed she was aware of the Care Plan for resident #12 but failed to follow proper protocols. Other residents identified as requiring two-person assist with ADL Care could have been affected by the actions of NA #1. Staff received education about the need to provide care in accordance with the Resident Care Plan on 11/29/18. 100% audit was completed on 2/27/19 by the Unit Managers regarding resident transfer/bed mobility assessments to ensure accurate, and on the nurse aid Kardex appropriately. Any deviations were corrected immediately. Nursing Leadership (Director of Nursing, Assistant Director of Nursing, Nurse Educator and Supervisors) Educated staff on 2/27/19 regarding the process for of Safe Resident Handling to include appropriate numbers of staff utilized for bed mobility and transfers based on Lift	

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F 689	Continued From page 5 memory problems and severely impaired cognitively for making daily decisions. Resident # 12 required total dependence and 2 person physical assistance with bed mobility, transfers, and toilet use. Review of the facility Event Summary Report, completed by Nurse # 1 dated 11/29/18 at 11:35 AM read in part, Nurse Aide NA # 1 reporting resident fell out of bed. Upon entering room found resident on the floor to the left side of the bed with her head lying at the foot end of the bed, urine noted on floor under resident. Right lower leg angled out to the side of her body. NA reporting that she was changing resident and had her turned on her left side, resident had a hold of the bedrail, reports somehow she flipped out of the bed to the floor. NA reports states that right leg slid in some food that was on the floor. Asked Resident if she was having some pain in her neck and head. Asked in Spanish from Spanish speaking NA, she shakes her head yes. Also shakes head yes for leg pain. Called office to report incident and that resident was being sent out to the hospital. Called doctor ' s office to report the incident and that the resident was being sent out t the hospital. 911 called. Family was called by another nurse. Leaves out of facility via stretcher. The root cause/ conclusion: Improper positioning during ADL care. On 2/26/19 at 3:46 PM a telephone interview was attempted with NA # 1, who was providing care for Resident # 12 when she fell from bed on 11/29/18, but her telephone number was no longer in service. A telephone interview was conducted on 2/26/19 at 2:15 PM with Nurse # 1 who responded to the resident ' s fall. Nurse # 1 stated when she	F 689	Assessments and plan of care, the process for ensuring that any question of equipment operability should be referred to Maintenance for evaluation, proper positioning for bed mobility and transfers, Furthermore, staff were educated that failing to use the appropriate number of staff for bed mobility and transfers would be treated as neglect of resident safety. Education included Full time/Part time/PRN and Agency staff members. Nursing Supervisors, Charge Nurses and the Nurse Practice Educator (NPE) will periodically monitor staff activity during the provision of care and any deficient practices will be referred to the NPE for additional education. Appropriate number of staff needed for bed mobility will be added to Resident Care Cards and Care Plans for staff reference. Five random audits will be conducted each week to assure appropriate procedures are followed for bed mobility and transfers according to the Plan of Care and Assessment. Facility will continue to discuss any falls from the previous day to determine cause and to assure proper interventions are in place. Falls will continue to be reviewed as Adverse Events at the monthly QAPI meetings. Necessary action plans and education will be provided to staff as indicated. Director of Nursing is responsible for the implementation of this plan.	

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F 689	Continued From page 6	F 689		

entered the room she found Resident # 12 lying on the right side of the bed on the floor with her head facing towards the end of the bed with her right leg bent at a weird angle. She stated there were urine and feces on floor and resident. She indicated she was focused on sending the resident out to the hospital for evaluation. The Nurse stated she called EMS, took Resident # 12 ' s vital signs and covered her up. The Nurse did not remember Resident # 12 crying or hollering out in pain. The Nurse stated she believed Resident # 12 had a bowel movement and the NA was cleaning her up at the time of the fall. She stated she did not remember if the head of the bed was up, however the bed was at high level and she lowered the bed for EMS to reach the resident.

Review of the local hospital emergency room report dated 11/29/18 read in part, that Resident # 12 presented with a right leg injury. "I spoke with the nurse at the nursing home. Apparently the aide was helping her and she fell from her bed onto the floor. She has a history of previous stroke."

Review of the X-ray completed on 11/29/18 revealed Resident # 12 had a right distal femur fracture.
Review of the general nursing note written by Nurse # 2 dated 11/29/18 at 7:42 PM documented Resident # 12 returned to the facility via emergency medical services on a stretcher at 6:34 PM in no distress. Resident has a diagnosis of a right distal femur fracture (broken leg.) Orders to keep resident ' s leg in an immobilizer, follow up with orthopedics in 7-12 days.

An interview was conducted with the RN Unit

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F 689	Continued From page 7	F 689		

Manager on 2/26/19 at 2:55 PM. The RN Unit Manager stated Nurse # 1 came and reported to her Resident # 12 had fallen and she was going to send her out to the ER. She stated Nurse # 1 reported to her that the NA was in the room alone, providing care when Resident # 12 fell out of the bed. She stated she brought the NA to the DON ' s office to interview. The NA reported she was providing care, the bed was broken at a 90 % angle and she continued to provide care. When asked if she had checked the bed prior to care the NA revealed she had not and had not gotten any help. The NA reported the head of bed was up and the bed was raised up high to provide incontinent care. The NA reported she gave care to her good side and as she began to roll Resident # 12 onto her right side she flipped out of the bed. The RN Manager stated that Resident # 12 was flaccid on her right side and was a 2 person assist with bed mobility and bathing. She stated staff first tended to Resident # 12 and after she was transported to the ER, staff checked her bed and found it to be working properly. The RN Unit Manger stated staff were in-Serviced to always provide 2 person assist when providing care and to check beds are working properly before providing resident care. Nurse # 1 stated she asked the NA if she attempted to get someone to help her give care, and NA # 1 stated that she did not ask anyone to help her with Resident # 12.

An interview was conducted with the Director of Nursing (DON) on 2/26/19 at 1:43 PM. The DON stated after the fall, the NA involved came to report Resident # 12 had a fall. The NA reported the head of the bed was stuck up at a 90 % angle and when she was using a draw sheet the resident flipped out of bed. The NA stated she

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F 689	Continued From page 8	F 689		

had not reported the bed was not working to the Maintenance man or nurse. The DON revealed when other staff entered the room to check the bed, it was working fine. She stated the NA was suspended pending their investigation and later terminated.

An interview was conducted with the Administrator on 2/28/19 at 2:42 PM. The Administrator stated they discussed Resident # 12 ' s fall and afterwards instructed staff to use 2 person assist with all resident transfers. He stated he would have expected the NA to get help when caring for Resident # 12. The Administrator stated the facility ' s investigation of Resident #12 ' s fall revealed the NA #1 failed to do anything right.