STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 11/26/19. Event ID# 668S11. 1 of the 6 complaint allegations was substantiated resulting in deficiencies.	F 000		
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: Based on record review, observations and staff and family interview, the facility failed to have a fall mat in place for a resident who sustained a fall, which resulted in a laceration, hematoma, and suture repair for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on 7/12/19 with the diagnoses of convulsions, rheumatoid arthritis, and atrial fibrillation. The resident had a care plan (initiated 8/1/19 and last revised 8/1/19) for behavior problems related to sliding out of the bed. An intervention revealed "ensure that low bed and fall mat is in place at all times when in bed." Resident #1's admission Minimum Data Set	F 689	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #1's fall mat has been put in place as indicated on the order and care plan. The intervention has also been added to resident #1's Treatment Administration Record for daily per shift documentation. 2. Facility conducted a facility wide audit of all residents identified as "high fall risk" to ensure that all orders and care plan interventions are active and in place. 3. A. Fall mat interventions have been added to the treatment administration	12/17/19

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

Electronically Signed | 12/11/2019

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F 689	Continued From page 1 dated 10/27/19 revealed the resident was moderately cognitively impaired. The resident had no behaviors present but had moods of feeling tired or having little energy. The resident required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. The resident required total dependence with transfers and locomotion on and off the unit. The resident used a wheelchair and was always incontinent of bowel and of bladder. The resident had a fall in the last 2-6 months prior to admission. The resident was receiving an anticoagulating medication for the last 7 days. Physician's orders for the month of 11/2019 revealed the resident was receiving Eliquis (an Anti-coagulant medication) twice daily for atrial fibrillation. An incident report dated 11/6/19 revealed staff were called to the resident's room by the nursing assistant (NA). The resident was observed lying face down on the floor beside of the bed. The resident had blood pooling under her. The resident complained of right arm, hand, and face pain. The resident stated "I get up wash hands" then the resident stated "no, the bed. I was trying to put my feet in the floor and flipped off the bed onto the floor". The emergency medical services (EMS) was called, and the resident was assessed for bleeding. The resident was turned over and the resident's right lower leg was noted to be bleeding under the dressing on the resident's leg. Pressure was applied to the right shin and an open area was noted to the resident's right hip. A hematoma (bleeding into tissues) was noted to the left brow and an abrasion was noted to the left knee. Predisposing factors revealed the resident was ambulating without assistance and	F 689	record (TAR) for each patient that has fall mat as a current intervention. This process will require the assigned nurse to visually verify the appropriate placement of the fall mat while resident is in bed, then document the placement of the fall mat on the TAR each shift. B. all licensed nurses are to be educated and trained on the new process requiring visual verification of the fall mat intervention placement and documentation on the TAR. C. The fall interventions (including fall mat placement) has been added to the “safety” section of the “Kardex” which is the resident specific care report used by the Nurse Aides. The “kardex” is reviewed and acknowledged by the Nurse Aides each shift as a daily task assignment. D. All certified nurse aides will receive training as to the addition of the fall mat intervention to the “safety” section of the individual resident “kardex”. 4. DON/Designee will audit 100% of residents with fall mat interventions weekly for 4 weeks, then monthly for 3 months. The audit will include a review of the TAR as well as a physical/visual inspection to ensure the physical placement of the intervention. Results of the audits will be reported to the QAPI committee monthly to determine the need for continued monitoring and or training.	

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had a gait imbalance. The resident was taken to the hospital.

A nursing note dated 11/6/19 written by Nurse #1 revealed at 6:10 PM, the writer was called to the room by the NA. The resident was observed lying face down on floor beside the bed. The resident was alert and verbally responsive. The resident was noted to have blood under her. The resident was turned over and assessed for blood. The right shin dressing was saturated with blood. Pressure was applied to her right shin and 911 was called. Resident #1 complained of right hand, arm pain, and face pain. A hematoma was noted to the left brow. At 6:30 PM, 911 Emergency Medical Services (EMS) arrived. The resident was taken to the emergency room. At 6:40 PM, the resident exited the facility via EMS.

A nursing note dated 11/6/19 written by Nurse #1 revealed at 6:10 PM, the resident stated, " I wash my hands." when ask what the resident was trying to do. The resident stated, " I was putting my feet on the floor and flipped out of the bed head first." The note stated, "Pt bed in lowest position."

Hospital records dated 11/6/19 revealed the resident was seen after a fall. The resident had a laceration to the right leg. The lacerating measured 4 centimeters. The note stated the laceration was deep and that 1 suture was placed. The resident was also started on an antibiotic due to the high risk of infection of the area due to peripheral vascular disease. No fracture was seen on X-RAY. The resident also sustained a contusion and facial hematoma. The note also revealed "regarding the Computed Tomography (CT) finding of the abnormal carotid as a non-emergent evaluation". The resident was

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discharged back to the facility.

A doctor's note dated 11/7/19 revealed resident #1 had severe rheumatoid arthritis, was bedridden with chronic peripheral vascular disease, chronic atrial fibrillation and was on chronic anticoagulation with Eliquis. The resident sustained a fall yesterday while she was leaning forward. She fell off the bed and struck her face against the floor and had a small laceration to the right leg. She denied any other complaint of syncope (dizziness), abdominal pain or chest pain. No fever or new complaints were noted. The head CT showed no acute intracranial pathology. The resident was resting comfortably in no acute distress. Dressing over the anterior shin on the right was clean, dry and intact. Some bruises were noted over both knees. The note stated to resume Eliquis and continue antibiotics.

Resident #1 was observed on 11/25/19 at 3:20 PM. The resident had a light, black circle under both of her eyes and a discolored area above her left brow. Her fall mat was in place and bed was in the lowest position.

Nursing Assistant #1 was interviewed on 11/26/19 at 2:02 PM. She stated she was not assigned Resident #1 that night (11/6/19). She stated she heard a weird, muffled noise and she went in the resident's room and saw her on the floor. She stated she got the nurse. The resident was lying face down. Her head was the same direction as the head of the bed. The bed was not in a high position. She stated she did not remember if the resident had a fall mat in place or not. She stated after she got the nurse, she let the nurses take over. She repeated that she did not recall anything about the fall mat. She added the

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resident was a fall risk.

NA #3 was interviewed on 11/26/19 at 3:45 PM. She stated the resident was incontinent and usually stayed in bed on her shift. She stated when she passed by the resident's door, the resident was on the floor. She stated herself and another NA were passing by the resident's room at the same time. The resident was on the floor and was bleeding. The other NA got the nurse. The resident's bed was in the low position. She stated she could not remember if there was a fall mat in place or not. They had to call 911 and send the resident to the emergency room. The resident usually had a fall mat in place. She revealed she couldn't remember if the resident had the fall mat in place for that day. She would go to the cardex on the computer or would ask the nurse how to care for the resident if she was unsure. They tried to keep the resident's bed in the lowest position, check the resident a lot, and keep water close to the resident to keep her from falling.

Nurse #1 was interviewed on 11/26/19 at 1:16 PM (who was assigned Resident #1 on 11/6/19). She stated when the resident fell it was towards the end of her shift. The Nursing Assistant (NA) got her and stated the resident was bleeding. She stated they put pressure on the resident's leg and called 911. She revealed she stayed with the resident and talked to the resident. The resident stated she was trying to wash her hands prior to the fall. The resident's bed was in the low position, but no fall mat was in place next to the resident's bed. She stated the resident did not have a fall mat at this time. This resident would try to get up when she was first admitted to the facility but then had stopped trying to get up, so this fall was surprising. The resident liked to sit on

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the side of the bed. She added the resident was lying face down with her face towards to wall (head of the bed) and her feet were towards the end of the bed.

NA #2 was interviewed on 11/26/19 at 3:36 PM. He stated Resident #1 was confused and had been on contact precautions. The resident was at risk for falls. He stated he was working the day the resident had a fall (11/6/19). The resident was found face down. He stated the resident tried to get out of the bed and was found on the floor. He could not recall if the fall mat was in place.

The resident's family was interviewed on 11/26/19 at 4:24 PM. She stated the resident had a fall and sustained a big bruise to her head, which caused her eye to swell up. The resident also required stiches to her leg; it was a deep wound. She stated she did not think the resident's fall mat was in place or the resident would not have sustained such a bad injury.

The resident's doctor was interviewed on 11/25/19 at 3:43 PM. He stated the resident was alert and oriented to herself only. He stated the resident had a fall and went to the hospital. He saw the resident the next day after the fall. He revealed the resident's mental status was back to normal. He assessed her eye and the resident for bleeding as she was on Eliquis. He had not been notified about any concerns with the dressing changes to the resident's leg.

The Director of Nursing (DON) was interviewed on 11/26/19 at 4:26 PM. She stated residents would have a fall risk assessment completed to see if they were at risk for falls. Therapy would also alert them if a resident was at risk for falls.

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The NAs have the Kardex to refer to, complete shift to shift hand offs, and have the nurses as a resource to ask if they are unsure how to care for a resident. She stated staff called her and let her know that Resident #1 had a fall (11/6/19). The resident was lying face down on the floor and the resident stated she was trying to wash her hands. She stated the resident already had a wound to her shin, but the wound had opened more after the fall. The resident had swelling to her eye. The resident had no major injuries but had a stitch to her leg. The resident did not have any long-term effects from the fall. She was made aware the resident's fall mat wasn't in place next to the resident's bed. The facility did a complete audit (on 11/15/19) of all the residents that were at risk for falls. She stated fall mats appeared as an order on the Treatment administration Record now. They also went through the rooms to make sure everything was in place for residents at risk for falls, including care plans and interventions. She stated, they didn't do an in-service on falls but mentioned it in the morning huddle to the inter-disciplinary team. She also added that the issue would be discussed in the next quality assurance meeting.

The Administrator was interviewed on 11/26/19 at 4:58 PM (DON was present). He stated he would expect if the resident scored high on the risk assessment as being a fall risk then there should be interventions in place to reduce the risk for falls and to minimize the injury.