JAN 0 9 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 12/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY NURSING AND REHABILITATION CENTER	714 WESTOVER DRIVE SANFORD, NC 27330

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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 observation, record review, and staff interviews, the facility failed to provide supervision in the shower room for 1 of 3 sampled residents (resident #1). Findings include: The facility policy, titled Bath/Tub, effective date 10/1/01, read in part "Procedure - Never leave a resident in the tub alone." Resident #1 was admitted to the facility on 2/11/09 and readmitted 4/27/10 with multiple diagnoses including cerebrovascular accident (CVA), expressive aphasia, and dementia. Review of the resident's Minimum Data Set (MDS) assessment dated 4/30/11 revealed the resident was severely cognitively impaired. The MDS indicated the resident required one-person physical assistance for bed mobility, dressing, and personal hygiene. The resident required one-person physical assistance in part of bathing. The MDS indicated the resident had no impairment in his functional range of motion. The resident ambulated in his wheelchair without assistance.	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **F 323** **Corrective Action for Resident Affected:** For Resident # 1, Resident was assisted out of the whirl pool tub on 5/13/11 and assessed for injuries and none were noted. **Corrective Action for Resident Potentially Affected:** All resident's requiring assistance with ADL's have the potential to be affected by the alleged deficient practice. An audit was conducted by the DON and all residents that require assistance with ADL's were identified. This was completed by 01-17-12. Any resident identified had their care plan reviewed by the DON and ensured the care plan included a, "Resident requires assistance with ADL's", problem. This was completed by 01-18-12.	1/17/12 1/18/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Glenn V. Reese, NHA	Administrator	1/17/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 1 The resident's Care Plan dated 10/3/11 indicated he required assistance with activities of daily living (ADLS) and was unable to communicate ADL needs effectively. Approaches included: encourage resident to participate in ADLS, set up supplies to perform personal hygiene, encourage resident to wash hands and face and assist to completion as needed, offer choices of type of bath to help resident feel more independent, monitor attempts at selfcare, and anticipate ADL needs. Record review revealed a Resident Incident Report dated 5/13/11 for resident #1. The report revealed the incident was reported to the supervisor on 5/13/11 at 5:00PM. The narrative and description of the incident revealed the resident was assisted into the whirl pool tub on 200 hall. The nursing assistant (NA) left the room to allow him privacy. A readmit came in and the NA was asked to assist with the physical assessment and she did. The resident was left in the whirl pool longer than usual. The report read in part "when he was assisted out of the whirl pool, the water was lukewarm and the resident seemed to be enjoying the whirl pool." The resident was assisted out of the whirl pool and dressed. Subsequent observations were documented and revealed "no complications noted from extended whirlpool." Record review revealed a typed statement dated 5/18/11 signed by NA #1. The statement read in part "I talked Mr. (resident #1) into taking a whirl pool room and assisted into the bath because he had not had his bath and was wearing the same clothes all week. When started to play with	F 323	**Systemic Changes** An in-service was conducted on 01/12/12 by the Director of Nursing. Those who attended were all Nursing Staff (RN's, LPN's and CNA's) FT, PT, and PRN. The facility specific inservice was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topic included: Providing continuous supervision for resident in the whirlpool/shower/bath. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. In addition to this, the Maintenance Director will install call lights that reach the two Whirl pool tubs and one shower identified as used by the facility residents by 01-18-12.	1/12/12 1/18/12

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F 323	Continued From page 2 himself, I stepped out into the hall to give him privacy. I left the door ajar. While I was in the hallway, the treatment nurse came and told me (resident's name) had a bowel movement and that he needed to be cleaned up right away because he had two small areas on his bottom. I immediately went to his room and cleaned him up. When I finished with him, I went across the hall and put (resident's name) to bed. When I came out of his room the 3-11 shift NA (NA #2) was on the floor. I gave her report and left. I do not remember what I told her in report I just remember that I talked to her like I do every day before leaving. I absolutely forgot that I had put Mr. (resident #1) in the whirl pool. I would never do anything to hurt one of our residents. I also promise that this will never happen again." A hand-written statement by NA #1 revealed resident #1 was placed in the whirlpool at 2:50PM. Record review revealed a signed, undated, hand-written statement by Nurse #1. The statement indicated Nurse #1 was working the 3-11 shift on 5/13/11. She began her shift around 2:30 PM. While getting report, the 7-3 nurse told someone to check on another patient when she was done with resident #1's whirlpool. Nurse #1 continued to get report and then began passing medications. She came to resident #1's room about 4:40PM. She checked his bathroom and the dining room. She began asking staff if they had seen him but no one had. She checked his room again. As she walked past the whirlpool room, nurse #1 pushed to open the door and saw resident #1 in the tub. The water was around his feet and lukewarm. Resident #1 stated he was fine, "just been waiting	F 323	**Quality Assurance** The Director of Nursing will monitor this issue using the "Providing Continuous Supervision for Residents in the Whirlpool/Shower/Bath QA Tool". The tool will monitor residents in the Whirlpool/Shower/Bath to ensure continuous supervision is being provided. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 323	Continued From page 3 a while." The nurse immediately got the resident out of the tub with the assistance of a nursing assistant. The nurse called the Director of Nursing (DON) and NA#1. The statement read in part "she (NA #1) was very upset and stated she had forgotten all about giving him a bath and had not reported that he was in the tub to the 3-11 aids." Record review revealed a typed statement, signed and dated 5/18/11, by Nurse #2. The statement read in part "on May 13, 2011, as I was leaving the building, I noticed some commotion on the 200 hall. It was approximately 5:15 to 5:30 PM. The charge nurse stated that Mr. (resident #1) was missing. In less than a minute's time, he was found in the whirlpool tub. A NA (NA#2) was in the room as well. Mr. (resident #1) was in his usual state of orientation, sitting in the whirlpool. He was talking and said he couldn't find the call bell. I asked about the water temperature and was told it was cool. At that time, the NA was assisting him out of the tub and the nurse was on the phone with the DON. Seeing that the resident was OK, I left the situation." In an interview on 12/21/11 at 2:36PM, NA #1 stated she was trained when hired and also attended in-service programs monthly. Her training included assisting with ADLS and bathing residents. NA #1 stated she worked with resident #1 daily. She stated the resident washed himself except for his back and needed someone to watch and guide him. The resident liked for the whirlpool tub to be in the most upright position. There were handrails on each side of the tub and the resident had no problems with sliding down.	F 323		

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F 323	Continued From page 4 He didn't like a lot of water in the tub, usually just below his knees. When he finished bathing, the resident dried and dressed him self but did need some coaching. NA #1 stated she put the resident in the whirlpool tub after 2PM on 5/13/11. She wasn't sure of the exact time. NA#1 stated she stood at the door of the shower room, which was partially opened, with the curtain pulled to give the resident some privacy. As she waited for the resident to bathe, she was called away to assist a nurse with a new admission. NA #1 stated she got side-tracked, as she had to complete her rounds and report to the 3-11 shift. She stated the facility called her at home after they found resident #1 in the whirlpool and asked her if he had been left there. She replied to the caller "O my God, I forgot him." NA#1 stated she completed a written statement the following day. During the interview, NA #1 accompanied this surveyor to the 200 hall shower room. NA#1 demonstrated a push button alarm on the opposite wall approximately 5 feet from the whirlpool tub. Observation revealed there were no other alarms or call bells in the shower room. NA #1 stated there was no way for the resident to call for assistance. She stated the facility policy was not to leave any resident alone in the whirlpool tub. In an interview on 12/21/11 at 3:23PM, NA #2 stated resident #1 bathed himself but needed some assistance at times. NA#2 stated she came in on second shift on 5/13/11 and started her duties. She didn't remember if NA#1 had given her a report for resident #1 that day. The resident was missing and found to be in the whirlpool. NA #2 assisted the resident out of the	F 323		

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F 323	Continued From page 5 tub but didn't remember what time he was found. She stated he was "OK" and sitting up in the tub when found. NA #2 stated whenever she was assigned a shower, she stayed in the shower room with the resident through the entire bath. She stated "as far as I know, it's facility policy. At least that's what I do anyway." In an interview on 12/21/11 at 3:36PM, NA #3 stated she came in after 3PM on 5/13/11. Resident #1 was usually in the lobby or dining room but was not there. The staff looked for him and found him alone in the whirlpool room. NA #3 was not assigned to him that day but she helped get him out of the tub. He was acting his "normal self" and sitting upright in the tub. The water was cold and his skin was wrinkled. She stated there was no way for the resident to ring the call bell since it was located on the wall next to the commode, away from the tub. NA #3 stated the resident didn't usually yell or call out for assistance but would use his call bell. In an interview on 12/21/11 at 4:57PM, the DON stated the staff was trained at orientation. After orientation, new hires were paired with a peer for training on the floor. The DON stated she received a call from the facility around 5:00 PM on 5/13/11 and was told resident #1 had been left in the whirlpool. She was told the resident was fine and the water was still lukewarm when he was found. NA #1 had left the shower room to give the resident some privacy and was called away by a nurse. The DON stated "she should have stayed with the resident and told the nurse she had someone in the whirlpool." The DON stated she investigated the incident and disciplined NA #1. Her expectation was for the	F 323		

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F 323	Continued From page 6 staff to stay with residents during their baths or showers. Nurse #1 and nurse #2 no longer worked at the facility and were unavailable for interview.	F 323		