


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345396 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 04/21/2012 |
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| NAME OF PROVIDER OR SUPPLIER SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 |
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| (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 |
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| F 280 SS=D | <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews the facility failed to ensure resident care plans were updated and reflected the residents' current care needs for two (2) of thirteen (13) residents. (Residents #7 and #68).</p> <p>The findings are:</p> <p>1. Resident #7 was readmitted to the facility on 03/02/11 with diagnoses including stroke, senile dementia, osteoporosis, atrial fibrillation, abnormal gait, difficulty in walking, and a history</p> | F 280 | <p>Smoky Mountain Health and Rehabilitation Center</p> <p>Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Smoky Mountain Health and Rehabilitation Center response to the statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate.</p> <p>Further, Smoky Mountain Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution or formal appeals procedure and or any other administrative or legal proceeding.</p> <p>F280</p> <p>Resident #7's care plan was updated on 04/19/2012 by the RN MDS Coordinator to reflect the current needs of the resident to include the use of the one way slide and the removal of bed and chair alarms.</p> <p>Resident #68's care plan was updated on 04/21/2012 by the MDS Nurse to reflect the current needs and interventions in relationship to the presence of a pressure ulcer to the right heel.</p> | 05/17/2012 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 5/14/12 |
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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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| F 280 | <p>Continued From page 1 of falls.</p> <p>The annual Minimum Data Set (MDS) dated 08/04/11 revealed Resident #7 was assessed to be moderately impaired for making daily care decisions, required limited assistance with walking, and required extensive assistance for transferring, bed mobility, and dressing. Resident #7 had a history of falls occurring in the past six months.</p> <p>The care area assessment (CAA) for falls dated 08/04/11 revealed Resident #7 was at risk for falls and had impaired balance. The CAA indicated a care plan would be developed for Resident #7 to address risk for falls.</p> <p>Review of Resident #7's current care plan last reviewed on 02/14/12 identified the resident at risk for falls. The care plan goal specified, "Resident will remain free of injury as evidenced by no injuries from falls or accidents thru this review." The care plan specified interventions for falls including provide bed and chair alarms, assist during transfer, rehabilitation therapy referral as needed, provide frequent reminders for resident to call for assistance before getting up, provide frequent staff observation of resident, resident to wear proper and non-slip footwear, and assist with toileting resident as needed.</p> <p>A Falls Committee note written by the Assistant Director of Nursing (ADON) dated 11/14/11 indicated bed and chair alarms were removed for Resident #7 due to no attempts to self-transfer in several months. The care plan for resident #7 was not updated.</p> | F 280 | <p>All resident's care plans were reviewed with revisions made as appropriate to reflect current needs by DON, RN MDS Coordinator, MDS Nurse and QI Nurse on 5/11/2012.</p> <p>Licensed Nurses in serviced on 5/11/2012 by Facility Consultant, DON and/or QI nurse on reviewing care plans, updating care plans and communicating current resident needs to include fall interventions, pressure ulcers and skin/wound interventions.</p> <p>An audit was completed on 5/10/2012 by the QI Nurse, DON, RN MDS Coordinator and MDS Nurse of all current care plans including Resident #7 and Resident #68 to monitor the updating of care plans to reflect current needs. Further audits will be completed by the QI Nurse, DON, RN MDS Coordinator and/or MDS Nurse weekly x 1 month, monthly x 3 then quarterly. Follow up action will be taken as indicated upon identification of potential issues by the QI Nurse, DON, RN MDS Coordinator and/or MDS Nurse.</p> <p>The care plan audit results will be forwarded by the QI Nurse to the weekly QA/QI Committee which consists of MDS Nurse, QI Nurse, Dietary Manager, DON, and Administrator. The QI Nurse will forward the audits to the Executive QI Committee which consists of the Medical Director, Pharmacy consultant, DON, MDS Nurse, QI nurse, and Administrator for review, the identification of potential trends, for follow up as deemed necessary and to determine the need for and frequency of continued monitoring. This process will be ongoing.</p> | |

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On 01/19/12 at 7:10 PM, a nurse's progress note revealed Resident #7 was found on the floor with her back against her bed and a half inch skin tear to her right shin. The resident stated that she slid out of her wheelchair onto the floor while trying to get into her bed.

A Falls Committee note by the ADON dated 01/23/12 revealed interventions of a one-way slide mat (non-skid) were implemented for Resident #7's wheelchair and staff were to continue to round frequently. Review of the care plan dated 02/14/12 revealed the one way slide (non-skid) mat was not added as a intervention to the care plan for resident #7.

During an interview on 04/20/12 at 3:15 PM, MDS Nurse #1 stated she did not know why the one way slide (non-skid) for Resident #7 ordered on 01/19/12 was not on the care plan. She further stated, "It should have been put on there." MDS Nurse #1 said current interventions to prevent falls for Resident #7 were not included in the care plan, including the one way slide mat. She further stated she was unaware of the personal and bed alarms being discontinued.

On 4/20/12 at 3:40 PM, an interview was conducted with the ADON. The ADON explained she reviewed all incident reports and did a root cause analysis on each incident. She further indicated that if interventions were put into place she alerted the care planning team and they added them to the care plan and the resident care guides. She stated new interventions were discussed in daily meetings but she could not recall specifically if the interventions of discontinuing alarms and adding the one-way

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Continued From page 3
slide mat were discussed.

2. Resident #68 was admitted to the facility on 03/01/12 with diagnoses including anorexia, failure to thrive, and depression.

The admission Minimum Data Set (MDS) dated 03/08/12 revealed moderately impaired cognition, extensive assistance with activities of daily living including bed mobility and toileting, and lower extremity limitation in range of motion. The MDS indicated risk of pressure ulcers but no unhealed pressure ulcers present on admission. The MDS also indicated pressure reduction devices for chair and bed, occasionally incontinent of urine, always continent of bowel, and use of a wheelchair for mobility. A pressure ulcer assessment dated 03/01/12 indicated Resident #68 was at high risk for development of pressure ulcers.

A review of the care plan dated 03/09/12 revealed interventions for skin integrity included: 1) staff to report to nurse any red or open areas, 2) re-align the resident's body after each repositioning, 3) cleanse perineal area well with each incontinence episode, 4) diet as ordered by physician, 5) dietary consult, 6) give medication as ordered by the physician, and 7) use two person transfer and use turn sheet to avoid friction/shearing of resident skin.

Review of Resident #68's medical record revealed an ulcer flow sheet dated 03/24/12 which noted the physician and the resident's responsible party both were notified on 03/23/12 of a pressure ulcer to the resident's right heel. According to the documentation, the ulcer was a

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Stage II, in-house acquired ulcer of questionable depth.

Further review of the care plan for Resident #68 revealed his care plan was not updated to reflect the presence of the pressure ulcer to his right heel or his current care needs related to the pressure ulcer.

Interview with MDS Nurse #2 on 04/20/12 at 4:25 PM revealed care plan reviews were done every three months and all care plan updates were done on the computer by adding interventions. The nurse said care plans were updated once all input from the nurses was received. MDS Nurse #2 also said the wound care nurse provided notification of the resident's pressure ulcer status via her wound report. When asked why the care plan for Resident #68 was not updated to reflect his existing ulcer, the nurse offered no explanation.

During an interview on 04/21/12 at 1:10 PM, the Director of Nursing (DON) said she expected the care plan to reflect the resident's current status, and the information should have been added to the care plan as soon as possible after they received the information.

F 280

F 281
SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and

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 medical record reviews, the facility failed to clarify the dose for an inhaled corticosteroid medication and properly complete medication administration for two (2) of ten (10) residents observed for medication administration. (Residents #50 and #148)
 The findings are:
 1. Resident #50 was readmitted to the facility on 04/12/12 with diagnoses including gastrointestinal bleed and chronic obstructive pulmonary disease. The admission Minimum Data Set dated 03/29/12 revealed moderately impaired cognition and extensive assistance for most activities of daily living.
 Review of the medical record for Resident #50 revealed a hand written physician's order sheet with an undated order for "Symbicort 160/45 inhaler b.i.d.[twice a day]." Review of the physician's orders revealed no clarification of the dose for the inhaler. Review of the April 2012 Medication Administration Record (MAR) revealed no dose specified for the Symbicort inhaler ordered for twice a day. Continued review of the MAR revealed documentation which indicated the resident received the inhaler medication once on 04/12/12, then twice daily 04/13-04/15/12.
 During an interview on 04/16/12 at 8:40 a.m., LN #5 stated Resident #50 was on two puffs before and had recently returned from the hospital. The nurse stated she did not realize the order on the MAR did not specify the dose and said the order should have been clarified.

F 281 F281
 Resident #50's Corticosteroid medication was clarified with the physician on 04/16/2012 by an Administrative RN.
 All current residents' medications were reviewed by the RN MDS Coordinator and Staff LPN on 4/29/2012 and 4/30/2012 for complete orders.
 Licensed Nurses and Medication Aides were in-serviced on 5/1/2012 by the Pharmacy Consultant, Facility Consultant, DON, and/ or QI Nurse on proper administration of medication to include the right resident, right administration of the medication, the right dose, the right route, the right time and the right documentation.
 Five random med pass observations were completed 5/10/2012 by the Pharmacy Consultant and the Facility Consultant.
 An audit monitoring for complete medication orders to include inhaled corticosteroid medication dosage will be done by the QI Nurse, DON and/or Administrative Nurse weekly x 1 month, then twice monthly x 1 month, then monthly x 3. Follow up action will occur upon identification of any potential issue by the QI Nurse, DON and/or Administrative Nurse. The QI Nurse, DON, or Designee will report the audit results to the weekly QA/QI Committee which consists of MDS Nurse, QI Nurse, Dietary Manager, DON, and Administrator. The QI Nurse will report audit results to the Executive QA/QI

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Interview with the Admissions Nurse on 04/16/12 at 8:45 AM revealed she was one of the two nurses who had reviewed the physician's orders that were then written on the MAR. She stated she missed seeing there was no dose specified for the Symbicort inhaler. The nurse stated they needed to get the order clarified.

During an interview on 04/16/12 at 8:53 AM, the Director of Nursing (DON) indicated the order missing the dosing information should have been identified by the nurses who reviewed the MAR. The DON stated they went by what they were initially sent and said the information probably came from the FL-2 form.

During an additional interview on 04/21/12 at 5:03 PM, the DON said she expected nurses to call the provider to get an unclear order clarified.

2. Resident #148 was admitted 04/12/12 with diagnoses including closed fracture of the tibia/fibula, closed fracture of the patella, and epilepsy. The admission Minimum Data Set dated 04/19/12 revealed intact cognition and extensive assistance for most activities of daily living.

On 04/16/12 at 3:58 PM, Licensed Nurse (LN) #2 was observed as she administered a narcotic pain medication and an anti-convulsant medication to resident #148. The nurse handed her a medication cup which contained the two pills, then turned and walked out of the room. The nurse did not stay to ensure the resident took the medication.

F 281

Committee which consists of the Medical Director, Pharmacy consultant, DON, MDS Nurse, QI nurse, and Administrator will review the audit results and make recommendations as appropriate.

Five Licensed Nurses and/or Medication Aides were observed by Pharmacy Consultant and Facility Consultant for proper administration of medication to include observation of taking of medication including Resident #148.

Licensed Nurses and Medication Aides were in-serviced on 5/1/2012 by the Pharmacy Consultant, Facility Consultant, DON, and/or QI Nurse on proper administration of medication to include the right resident, right administration of the medication, the right dose, the right route, the right time, the right documentation and self administration of medications.

Five random med pass observations were completed 5/10/2012 by the Pharmacy Consultant and the Facility Consultant.

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| F 281 | Continued From page 7 During an interview on 04/16/12 at 4:00 PM, LN #2 said it was not her usual practice to leave the room without watching residents take their medications. The nurse stated she did not realize the resident had not yet taken the medication when she left the room. Interview with the Director of Nursing on 04/21/12 at 5:03 PM revealed she expected nurses to make sure medications being administered to residents were actually taken. | F 281 | Med Pass Observations to include Resident #148 will be conducted by the Pharmacy Consultant, DON, QI Nurse and/or Administrative Nurse will be done weekly x 1 month, then twice monthly x 1 month, then monthly x 3. Follow up action will occur upon identification of any potential issue by the QI Nurse, DON and/or Administrative Nurse. The QI Nurse, DON, or Designee will report the audit results to the weekly QA/QI Committee which consists of MDS Nurse, QI Nurse, Dietary Manager, DON, and Administrator. The QI Nurse will report audit results to the Executive QA/QI Committee | |
| F 309 SS=E | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff interviews and physician interview the facility failed to assess two (2) of four (4) residents who required neurological evaluations after a fall. (Residents #8 and #100) The findings are: Review of the undated facility policy for Neurological Examination read, "Neurological examinations will supply a source of information to assist with diagnosing and planning the therapeutic management of the resident. A | F 309 | which consists of the Medical Director, Pharmacy consultant, DON, MDS Nurse, QI nurse, and Administrator will review the audit results and make recommendations as appropriate. F309 Resident #100 is no longer in the facility. Resident #8 was placed on one on one titrating observations beginning on 4/18/2012 ending on 05/02/2012 after the resident was determined to be safe. The resident was placed in a Scoot Chair with a self releasing alarming seat belt, one way glide on cushion, Dycem under cushion to prevent sliding and mats on the floor when in bed. All Current residents with falls have been reviewed for proper assessment to include neurological evaluations on 5/08/2012 by the DON and QI Nurse with no issues identified. | 05/17/2012 |

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licensed nurse will do this examination with the results documented in the resident's medical record. Any abnormal findings will be reported to the designated registered nurse and/or attending physician. When there is evidence of head injury, change in muscle strength, or sensation disturbances, a neurological examination should occur. The findings will be documented along with the description of how and when the accident/injury occurred or when the resident experienced a change in condition. A complete description of these symptoms will aid in the diagnosis and therapeutic management of the resident."

1. Resident #8 had diagnoses which included Parkinsons disease, cataracts, hypotension, arthritis and muscle weakness. A significant change Minimum Data Set (MDS) of 12/12/11 specified Resident #8 had moderately impaired cognitive skills and required extensive assistance with transfers and toileting.

Review of the medical record of Resident #8, incident reports and facility response included the following:

a. A nurses note dated 12/27/11 at 11:15 AM noted: "Resident noted to be lying on the floor on her back with her right knee bent up against wall. Complained of pain her right leg" and "Right foot rotated outward, complained of right lower leg being numb, area of erythema noted on forehead. Alert, communicating verbally as usual, but crying with pain. Resident made as comfortable as possible with pillow and blanket. EMS notified".

Hospital discharge records dated 12/27/11

F 309 In -services were completed on 04/18/2012 by Facility Consultant, QI Nurse, and/or DON for all licensed staff. The in service included: Neuro checks must be initiated for all unobserved falls and observed falls that resulted in a head injury. The neuro checks will be conducted for a total of 24 hours or until resolved and documented in the electronic record. 100% of all staff was in serviced on Fall Prevention and what to do if a fall was observed on 04/22/2012 by the Facility Consultant, DON and/or QI Nurse.

An audit to monitor the completion of neuro checks for unobserved falls and observed falls with head injury will be completed by the QI Nurse, DON, or Designee on any resident to include Resident #8 when an unobserved fall or observed fall with a head injury occurs weekly x 1 month, monthly x 3 months, then quarterly on an ongoing basis. The DON or QI Nurse will follow up on any potential concern identified as needed with additional training for involved staff conducted as appropriate.

The results of these audits will be forwarded by the QI Nurse to the weekly QI Committee which consists of MDS Nurse, QI Nurse, Dietary Manager, DON, and Administrator. The QI Nurse will forward audit results to the Executive QA/QI Committee which consists of the Medical Director, Pharmacy consultant, DON, MDS Nurse, QI nurse, and Administrator for review, the identification of potential trends, for follow up as deemed necessary and to determine the need for and frequency of continued monitoring as appropriate.

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indicated Resident #8 had an acute urinary tract infection and a contusion of the left thigh.

A nurses note dated 12/27/11 at 6:11 PM noted: Resident returned to the facility from the ER (approximately 6 hours after she was transported to the ER) at 6:10 PM.

Review of nurses' notes did not include any neurological assessments for a 24 hour period after the fall (beyond the initial physical assessment for injuries).

On 04/20/12 at 5:00 PM LN #2 (who readmitted Resident #8 on 12/27/11) stated she would have initiated a neurological check sheet and the neurological check sheet would have been passed to oncoming shifts. LN#2 stated sometimes the neurological checks are recorded on a piece of paper (showed an example, like the vital sign sheet) that may not have become a part of the medical record. LN #2 could not recall if neurological checks were done after Resident #8's fall on 12/27/11.

b. An incident report dated 01/12/12 at 6:30 PM indicated: "Nursing assistant heard resident yelling for help. Upon arrival to resident room this nurse found resident on floor with wheelchair on top of resident. Resident's head was resting partly on the footrest of the wheelchair and on a bolt on resident's roommates bed frame. Two nursing assistants and this nurse removed wheelchair from on top of resident. After assessing resident, two nursing assistants and this nurse assisted resident back into bed. Resident was bleeding a small amount from right of head. On call physician notified and ordered to

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| F 309 | <p>Continued From page 10</p> <p>send resident to ER for evaluation and treatment. Resident could not explain to this nurse why she fell out of her wheelchair".</p> <p>Hospital discharge records on 01/12/12 indicated the resident had a 1 cm (centimeter) laceration above the right temple which was closed with sutures. Hospital discharge records indicated the resident had a minor head injury and that the resident should be checked on frequently for the next 24 hours.</p> <p>A nurse's note dated 01/13/12 at 4:47 AM noted: Resident returned from ER (on 1/12/12 at 11:00 PM) with three stitches placed in side of head (a little over four hours after leaving the facility). There was no evidence of neuro checks on readmission or for the 24 hours after the fall and return from the ER.</p> <p>On 4/21/12 at 3:45 PM LN #5 (who readmitted Resident #8 on 1/12/12) stated typically she would have done neurological checks on Resident #8 on readmission and they would have been written on a sheet of paper. LN #5 could not recall if neurological checks were done after Resident #8's fall on 1/12/12.</p> <p>c. An incident report dated 01/14/12 at 7:20 PM indicated: "This nurse gave resident bedtime medication. A few minutes later this nurse heard a bang and resident yelling. Upon arriving to resident room this nurse found resident lying on floor at the foot of her wheelchair with her head against the wall. This nurse, along with two nursing assistants, assisted resident to a comfortable position and continued to hold pressure to resident's right side of her head. On</p> | F 309 | | |

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| F 309 | <p>Continued From page 11</p> <p>call physician notified and ordered to send to ER for evaluation and treatment".</p> <p>Hospital discharge records on 01/14/12 indicated the resident had a skin tear with hematoma to her forehead as well as pain to her left shoulder.</p> <p>Review of the medical record revealed there was not a nurses note when Resident #8 was returned from the ER. In addition there was no evidence of neurological checks in the resident's medical record for the 24 hour period after the fall and return from the ER.</p> <p>On 04/20/12 at 12:44 PM the DON stated the licensed nurse that was on duty when Resident #8 returned from the ER was no longer employed by the facility and contact information was not available.</p> <p>Nurses notes and hospital discharge records in the medical record of Resident #8 indicated the resident was hospitalized 01/29/12-01/31/12 with the primary diagnoses of bilateral pulmonary embolism. Coumadin was initiated in the hospital and has continued on Coumadin through the time of the survey.</p> <p>d. A nurse's note dated 03/11/12 at 11:24 AM noted: "10:00 AM Patient found on floor in bathroom beside toilet with head against the wall" and "Patient alert and crying, complains of pain to back of head, no bleeding noted. Quarter sized knot noted and redness across shoulder blades. EMS notified".</p> <p>Hospital discharge records dated 03/11/12 indicated: Minor closed head injury without loss</p> | F 309 | | |

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| F 309 | <p>Continued From page 12</p> <p>of consciousness, acute cervical strain and a contusion to her right shoulder. Hospital discharge instructions dated 03/11/12 included: Head injury precautions: An observer must check on the patient every two hours for the next 24 hours (awaken if sleeping) to confirm that the patient responds as expected, is not confused, has no new weakness or numbness, and has no other problems.</p> <p>A nurses note dated 03/11/12 at 3:03 PM noted: Patient returned via EMS from ER(approximately 5 hours after she left the facility). There were no neuro checks in the medical record after return from the ER on 03/11/12 or for the 24 hour period after the fall.</p> <p>On 04/21/12 at 4:25 PM LN #7 (who was on duty when Resident #8 returned from the ER on 03/11/12) stated that because the resident returned during the change of shift she thought the oncoming nurse would have initiated neuro checks. LN #7 stated neuro checks should have been initiated and recorded in the nurses notes.</p> <p>On 04/20/12 at 5:00 PM LN #2 (who was on duty 03/11/12 from 3PM-3AM) stated if a resident falls she usually tries to chart on them every shift. LN#2 stated sometimes the neuro checks are recorded on a piece of paper (showed an example, like the vital sign sheet) that may not have become a part of the medical record. LN #2 stated she could not recall if neuro checks were done for Resident #8 after the fall on 03/11/12.</p> <p>On 04/21/12 at 11:00 AM LN #3 (who worked 3AM-3PM on 03/12/12) stated her usual practice for residents readmitted with a head injury is to</p> | F 309 | | |

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| F 309 | <p>Continued From page 13</p> <p>observe their head and check vitals. LN #3 stated she normally documented findings in the electronic nurses notes. LN #3 stated if there was an order to monitor a resident she would do neuro checks which would be documented on the facility neuro check form and included in the medical record. LN #3 stated she could not recall if neuro checks were done for Resident #8 after the fall on 03/11/12.</p> <p>e. A nurses note dated 04/11/12 at 8:54 PM noted: "This nurse heard a loud noise from the hallway. Upon entering room I saw resident laying face down on the floor beside her bed and the wall. Her wheelchair was on top of her. Resident was alert. Bloody drainage noted from left hand. Resident moved with the lift to her bed. Resident moaning and crying that she hurt all over. Moves extremities slowly and crying aloud". "Call to 911 for transport to ER".</p> <p>Hospital discharge records dated 04/11/12 specified: Minor closed head injury without loss of consciousness, multiple abrasions to the right knee and left hand and multiple contusions with soft tissue hematoma to the head, right knee and left hand. Hospital discharge records on 04/11/12 included head injury precautions noting an observer must check on the patient every 2 hours for the next 24 hours (awaken if sleeping) to confirm that the patient responds as expected, is not confused, has no new weakness or numbness, and has no other problems.</p> <p>A nurses note dated 04/11/12 at 11:26 PM noted: Resident returned from the hospital ER (approximately 3 hours after leaving the facility). There was no evidence of neuro checks upon</p> | F 309 | | |
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| F 309 | <p>Continued From page 14</p> <p>return to the facility from the ER for the 24 hour period after the fall.</p> <p>On 04/21/12 at 4:00 PM LN #2 (who was on duty when Resident #8 returned on 04/11/12 at 11:54 PM) stated neuro checks would have been done. LN #2 stated sometimes the neuro checks are put on a separate piece of paper (showed an example, like the vital sign sheet) that are passed on to oncoming nurses. LN #2 stated she couldn't explain what happened to those papers.</p> <p>Resident #8 was observed the first day of the survey on 04/16/12 at 7:25 AM with dark purple bruising on her forehead, around a significant portion of her right eye and bridge of her nose; covering approximately a 16 cm by 7 cm wide area. When questioned, Resident #8 stated she fell a couple days prior.</p> <p>On 04/18/12 at 10:30 AM the physician (MD) of Resident #8 stated nurses should monitor level of consciousness, pupils, vital signs, behavior, pain, any latent injury to skin such as bruises/abrasions after a fall. The MD stated after a fall a resident should be monitored for several hours. The MD stated she thought it was a standard of practice to do neuro checks on a resident after any falls. The MD stated Resident #8's falls were extremely concerning because of her being on Coumadin (a blood thinner). On 04/18/12 at 3:50 PM in a follow-up interview, the MD of Resident #8 stated she wasn't aware the facility didn't have a written protocol for neurological checks. The MD stated she was under the impression neurological checks would be done as part of the follow up assessment of a fall if a resident hit their head. The MD stated she feels sure the other MDs in</p> | F 309 | | |
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| F 309 | <p>Continued From page 15</p> <p>her practice were under the same impression about neurological checks.</p> <p>On 04/18/12 at 4:30 PM the medical director of the facility stated he expected a resident to be assessed with neurological checks after a fall with a head injury or if it is unknown if there is a head injury. The medical director stated neurological checks should be done for 24 hours. The medical director stated he wasn't aware the facility didn't have a protocol for doing neurological checks. The medical director stated he thinks the other physicians in his practice that share call with him are under the impression that neurological checks would be a standard part of assessing residents after falls with head injury.</p> <p>2. Resident #100 was admitted to the facility on 11/30/11 with diagnoses including altered mental status, fluid and electrolyte imbalance, and urinary incontinence. The admission Minimum Data Set dated 12/07/11 revealed moderately impaired cognition, limited assistance with transfers and ambulation, and history of falls.</p> <p>Review of the progress note written on 03/19/12 at 7:25 AM for Resident #100 revealed she was found on the floor with a large hematoma noted over her right eye and extensive bruising to her right hand, left forearm, and left foot. The nurse noted the resident moved all extremities per usual, remained alert, and emergency medical services (EMS) was called to transfer her to the emergency room (ER). The nurse noted she was transferred to the ER at 6:40 AM.</p> <p>Review of hospital discharge records for Resident #100's ER visit 3/19/12 revealed documentation</p> | F 309 | | |

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she was transported back to the facility on 03/19/12 at 9:10 AM. The hospital records also included documentation that "report was given to a nurse via phone call. Report included patient's care, treatment, medications and condition (including any recent changes or anticipated changes). All questions were answered. Report was acknowledged and care was transferred. (name of Licensed Nurse #3)" Further review of the hospital record revealed hospital discharge instructions which included ice to the hematoma area and the following head injury precautions: "An observer must check on the patient frequently for the next 24 hours to confirm that the resident responds as expected, is not confused, has no new weakness or numbness, and has no other problems."

Continued review of the progress notes for Resident #100 revealed no further nursing documentation until 03/20/12 at 1:48 AM when the nurse noted the resident was resting quietly in bed with daughter at the bedside, dressings to right eye area, left arm and foot dry and intact. The nurse also documented "Extensive bruising noted over all of body. Denies pain at this time. Bed in low position with mat on floor for safety. Will continue to monitor and assist as needed."

Interview with the Director of Nursing (DON) on 4/17/12 at 5:28 PM revealed nurses were expected to assess residents for any abnormalities after their return from the ER and document in the nurse's notes. The DON said she expected nurses to follow standards learned in nursing school and initiate neuro checks if a head injury was suspected.

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| F 309 | <p>Continued From page 17</p> <p>Further interview with the DON 04/20/12 at 8:45 AM revealed ER instructions should be followed by nurses. The DON stated the instructions would not be written as an order but would be implemented.</p> <p>Interview on 04/21/12 at 10:57 AM with Licensed Nurse (LN) #3 revealed she was not at the facility when the resident fell but was the nurse for her when she came back from the hospital. LN #3 stated report was called to her but she didn't recall any instructions from the nurse at the hospital and didn't remember seeing any written instructions from the hospital discharge. The nurse said she usually documented findings in the nurse's notes and confirmed she didn't make a note of when Resident #100 came back. LN #3 said there was a form they used to record neurological findings on; when asked if she completed one for the resident's 03/19/12 fall, the nurse stated she could not recall. The nurse said she checked Resident #10 then clarified she talked to her, checked her vital signs, hand grips and legs/feet strength, and observed the dressing to the area above her eye. She also said Resident #100 talked with slurred speech but that was normal for her. LN #3 said she did not apply ice to the hematoma nor did she do any further checking for neurological findings for Resident #100 but did check on her "about every 30-45 minutes." LN #3 said she checked on her often, but "after that she went to sleep so I didn't bother her much."</p> | F 309 | | |
| F 323 SS=G | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards</p> | F 323 | | |

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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 medical record review, observations, staff interviews and physician interview the facility failed to implement measures to prevent falls for two (2) of six (6) sampled residents with a history of falls. (Residents #7 and #8)

The findings are:

- Resident #8 had diagnoses which included Parkinson's disease, cataracts, hypotension, arthritis and muscle weakness. Review of a 12/08/11 "Falls committee" note revealed Resident #8 experienced multiple falls over last several months and she refused to use the call bell to request assistance. Staff were to "round frequently" to assess for resident needs.

A significant change Minimum Data Set (MDS) of 12/12/11 specified Resident #8 had moderately impaired cognitive skills and required extensive assistance with transfers and toileting. The resident's "Falls" Care Area Assessment (CAA) dated 12/15/11 read, "Long term resident of facility that has history of falls. Resident is able to call for assistance as needed. Will address in care plan".

Review of Resident #8's care plan, that was in place on 12/15/11, included the problem area,

F 323 F323

Resident #8 was placed on one on one observation starting on 04/18/2012 observations ending on 05/02/2012 after the resident was determined to be safe. The resident was placed in a Scoot Chair with a self releasing alarming seat belt, one way slide on cushion, Dycem under cushion to prevent sliding and mats on the floor when in bed.

Resident #7 was placed in a Scoot Chair with Dycem placed under the cushion and a one way slide over the cushion to prevent sliding, a mat to the left side of the bed, personal alarm, bed alarm and a winged mattress.

Fall Risk Assessments were completed on 04/18/2012 by the RN MDS Coordinator and MDS Nurse for current residents. Interventions put in place for residents identified with fall risks with preventive interventions deemed appropriate. All new admissions will be assessed for a fall risk by the admitting nurse with interventions deemed appropriate put in place. The Clinical Morning Meeting which consists of the Administrator, QI Nurse, DON, RN MDS Coordinator, MDS Nurse, Rehab and Social Services will review interventions and refer to the Interdisciplinary Care Plan Team which consists of the Administrator, MDS Nurse, Social Services, Activities Director, Dietary Manager, DON and Rehab as deemed necessary.

In services were completed by the Facility Consultant, QI Nurse, and/or DON on 04/22/2012 for the licensed staff. In service included placing an intervention when the Fall Risk Assessment identifies a resident as a fall risk.

05/17/2012

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| NAME OF PROVIDER OR SUPPLIER SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 |
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"Risk for falls characterized by history of falls/multiple risk factors related to: disease process (Parkinsonism); unsteady gait." The goal to this problem area included: "Resident will remain free of injury as evidenced by no injuries from falls or accidents thru review period." Approaches to address the problem area included: assist during transfer and mobility, encourage resident to take rest periods as needed, observe for decline or change in mobility and refer to therapy as indicated, have commonly used articles within easy reach, provide frequent reminders to resident to call for assistance before getting up, resident to wear proper and non slip footwear and encourage use of wheelchair when out of bed for mobility.

Review of Resident #8's medical record revealed that from 12/17/11 to 04/17/12 she experienced a total of eleven (11) unsupervised falls which occurred on the following dates; 12/17/11, 12/19/11, 12/27/11, 01/12/12, 01/14/12, 01/19/12, 03/11/12, 03/27/12, 04/01/12, 04/11/12 and 04/17/12. Further medical record review revealed Resident #8 was injured during five (5) of these unsupervised falls on the following dates:

12/27/11: Found on floor on her back with right knee bent up against wall with her right foot rotated outward. A radiology report of 12/29/11 revealed Resident #8 experienced a fractured right toe.

01/12/12: Found in room on floor with her wheel chair resting on top of her. Resident had small amount of bleeding from right side of head and sent to Emergency room for evaluation. Hospital records of 01/12/12 revealed Resident #8 had a

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An audit to monitor the implementation of appropriate interventions to prevent falls for all residents to include Residents #7 and #8 will be completed by the QI Nurse, DON or Administrative Nurse weekly x 4, then monthly ongoing. The DON, QI Nurse or Administrative Nurse will follow up as indicated on any potential identified area of concern.

The audit results will be forwarded by the QI Nurse to the weekly QI Committee which consists of MDS Nurse, QI Nurse, Dietary Manager, DON, and Administrator. The results of these audits will be forwarded by the QI Nurse to the Executive QI Committee which consists of the Medical Director, Pharmacy consultant, DON, MDS Nurse, QI nurse, and Administrator for review, the identification of potential issues for follow up as necessary and to determine the need for and frequency of continued monitoring as appropriate.

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| F 323 | <p>Continued From page 20</p> <p>laceration above her right temple which was closed with sutures.</p> <p>01/14/12: Found in room on floor in a small puddle of blood. Hospital records of 01/14/12 revealed Resident #8 had a skin tear with hematoma to her forehead as well as pain to her left shoulder.</p> <p>03/11/12: Found in bathroom on floor with head against the wall with a quarter sized knot and redness to across shoulder blades. Hospital records of 03/11/12 specified that Resident #8 experienced an acute cervical strain and contusion to her right shoulder.</p> <p>04/11/12: Found in room on floor lying face down with her wheelchair on top of her and bloody drainage noted from left hand. Hospital records of 04/11/12 specified that Resident #8 experienced multiple abrasions to right knee and left hand and with multiple contusions with soft tissue hematoma to head, right knee and left hand.</p> <p>Observations of Resident #8 on 04/16/12 at 7:25 AM revealed she had a dark purple bruise on her forehead, around a significant portion of her right eye and bridge of her nose which covered approximately a 16 cm by 7 cm wide area. When questioned, Resident #8 stated that a couple days ago she fell.</p> <p>On 04/18/12 at 10:30 AM Resident #8's physician (MD) was interviewed. The physician stated that Resident #8 was predisposed to falls due to Parkinson's disease. The MD stated physical therapy had been tried to improve functional ability but because of Parkinson's disease</p> | F 323 | | |
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| F 323 | <p>Continued From page 21</p> <p>Resident #8 did not have the ability to self-correct if she got off balance. The MD stated after Resident #8 worked with physical therapy she thought she could do more than she is capable of doing and attempts to transfer herself and falls. The MD stated staff try to keep Resident #8 in her wheelchair because she could not ambulate safely noting most of her falls occurred when she attempted to self-transfer.</p> <p>On 04/20/12 at 9:10 AM the occupational therapist (OTR) reported Resident #8 was a difficult resident due to memory problems, no attention to task and control issues related to the Parkinson's. The OTR stated Resident #8 had no desire to be safe and that staff had to stay with her when toileting and transferring because Resident #8 would move impulsively. The OTR stated in the past changes had been made for Resident #8 which included placing her in a lower wheelchair with antitippers and a wedge cushion. The OTR stated Resident #8 was currently being assessed for interventions to prevent future falls.</p> <p>On 04/20/12 at 12:35 PM the Director of Nursing (DON), Assistant Director of Nursing (ADON) and MDS Coordinators #1 and #2 were interviewed regarding Resident #8's eleven (11) unsupervised falls experienced from 12/17/11 to 04/17/12. Staff confirmed that during this time period five (5) of these falls resulted in Resident #8 being injured. During this interview staff provided the following information regarding the eleven (11) unsupervised falls experienced by Resident #8 since 12/17/11 and the facility's response to each of these falls:</p> <p>12/17/11- The DON confirmed that the nurse</p> | F 323 | | |
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| F 323 | <p>Continued From page 22</p> <p>should not have left Resident #8 unattended in bathroom. MDS Coordinator #2 stated that no other interventions were implemented to prevent further falls.</p> <p>12/19/11- The DON confirmed that Resident #8 was unsupervised during this fall and she experienced bruised buttocks. MDS Coordinator #2 specified the only change made to the resident's care plan was to remove the use of bed and chair alarms.</p> <p>12/27/11- The DON confirmed that Resident #8 was unsupervised during this fall and experienced a fractured toe. The DON stated that nursing assistants were educated on the importance of staying with residents. MDS coordinator #2 confirmed that no changes were made to Resident #8's care plan.</p> <p>1/12/12- The DON confirmed the resident was unsupervised during this fall and experienced a laceration to her right temple which required sutures. The DON stated in response to this fall the physician ordered anti tippers to the resident's wheel chair on 1/13/12.</p> <p>1/14/12- The DON confirmed the resident was unsupervised during this fall and experienced skin tear with hematoma to her forehead. The ADON stated that the falls committee's response, to the resident's falls which occurred on 1/12/12 and 1/14/12, was place anti tippers on the resident's wheel chair.</p> <p>1/19/12- The DON confirmed that Resident #8 was unsupervised during this fall. The ADON stated that in response to this fall the facility</p> | F 323 | | |
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| F 323 | <p>Continued From page 23</p> <p>placed a one way non skid cushion in Resident #8's wheel chair to keep her from getting out of her wheel chair unassisted.</p> <p>03/11/12- The DON confirmed that Resident #8 was unsupervised during this fall and experienced an acute cervical strain and contusion to her right shoulder. ADON confirmed that although the resident was injured from this fall no other interventions were implemented to prevent further falls.</p> <p>03/27/12- The DON confirmed that Resident #8 was unsupervised during this fall. The ADON and MDS Coordinator #2 confirmed no other interventions were implemented to prevent further falls.</p> <p>04/01/12- The DON confirmed that Resident #8 was unsupervised during this fall. Resident #8 was seen by a psychiatrist on 04/03/12 to evaluate for "cognition and mood", but no recommendations were made regarding the resident's falls.</p> <p>04/11/12- The DON confirmed that Resident #8 was unsupervised during this fall which resulted in injuries. In response to this fall the was social worker to discuss the resident's noncompliance with falls interventions.</p> <p>04/17/12- The DON confirmed that Resident #8 was unsupervised during this fall. The facility's response to this fall was to implement a rock and go wheel chair with self release alarm belt.</p> <p>On 04/20/12 at 3:05 PM Nursing Assistant (NA) #1, who regularly worked with Resident #8, was</p> | F 323 | | |
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| F 323 | <p>Continued From page 24</p> <p>interviewed. NA #1 stated that she had worked with Resident #8 for a couple years and despite telling the resident to call for assistance she would attempt to care for herself independently. NA #1 stated that she tried to check on Resident #8 every one to two hours, but Resident #8 would not consistently allow staff to assist with toileting.</p> <p>2. Resident #7 was readmitted to the facility on 03/02/11 with diagnoses including stroke, senile dementia, osteoporosis, atrial fibrillation, abnormal gait, difficulty in walking, and personal history of falls.</p> <p>The annual Minimum Data Set (MDS) dated 08/04/11 revealed she was assessed to be moderately impaired for making daily care decisions, required limited assistance with walking, and required extensive assistance for transferring, bed mobility, dressing. Resident #7 had a history of falls occurring in the past six months. Resident #7's quarterly MDS dated 02/03/12 specified she had experienced falls; she was assessed to be severely impaired for making daily decisions, and required extensive assistance of one person for transfer, bathing, bed mobility and hygiene.</p> <p>The Care Area Assessment (CAA) dated 08/04/11 revealed Resident #7 was at risk for falls and had impaired balance.</p> <p>A review of the care plan dated 08/04/11 and updated on 02/09/12 identified the resident at "Risk for falls." The care plan's goal specified, "Resident will remain free of injury as evidenced by no injuries from falls or accidents thru this review." The care plan specified interventions for</p> | F 323 | | |
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| F 323 | <p>Continued From page 25</p> <p>falls including: "provide personal alarm and bed alarm; assist during transfer; rehabilitation therapy referral as needed; provide frequent reminders for resident to call for assistance before getting up; provide frequent staff observation of resident; resident to wear proper and non-slip footwear; and assist with toileting resident as needed."</p> <p>Review of a Licensed Nurse (LN) progress note dated 08/16/11 revealed Resident #7 attempted to get out of bed without assistance and sat on the floor. Nurse's notes dated 08/16/11 at 11:19 PM stated the bed alarm was in place and that Resident #7 received a six (6) centimeter skin tear to her lower outer leg.</p> <p>A Falls Committee note signed by the Assistant Director of Nursing (ADON) dated 08/17/11 revealed, "Resident encouraged to use call bell for assistance with transfer, staff instructed to round frequently to anticipate resident needs."</p> <p>Review of a LN progress note dated 09/09/11 at 9:20 PM Resident #7 fell forward from her wheelchair, hit the floor, and developed a large hematoma to her left forehead. The resident was sent to the emergency department after consultation with the physician and discharged back to the facility on 09/10/12 early in the morning. No information on facility review of this incident could be located. There was no documentation of alarms being in use. No new interventions were documented as being implemented.</p> <p>Review of a LN progress note dated 10/16/11 at 9:45 PM revealed the resident was observed by</p> | F 323 | | |
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| F 323 | <p>Continued From page 26</p> <p>three facility staff members as she attempted to get out of bed without assistance. Resident #7 fell backwards across bed striking the over bed table slightly with the top right side of her head. No information on facility review of this incident could be located. No new interventions were documented as being implemented.</p> <p>A Falls Committee note signed by the ADON dated 11/14/11 indicated the personal alarms were removed for Resident #7 due to no attempts to self-transfer in several months.</p> <p>Review of a Licensed Nurse (LN) progress note dated 01/11/12 at 8:51 PM stated Resident #7 was "found in floor next to her bed resting her back against the bed." No injuries were reported.</p> <p>A Falls Committee note signed by the ADON dated 01/12/12 stated the resident was reviewed for the unobserved fall and staff was educated on the importance of placing the resident in non-skid footwear.</p> <p>Review of a LN progress note dated 01/19/12 at 7:10 PM revealed Resident #7 was found on the floor with her back against her bed with a half inch skin tear to her right shin. The resident stated that she slid out of her wheelchair onto the floor while trying to get into her bed.</p> <p>A Falls Committee note signed by the ADON dated 01/23/12 indicated a one-way slide mat (non-skid) was implemented for Resident #7's wheelchair and staff was to continue to round frequently.</p> <p>Review of a LN progress note dated 04/15/12 at</p> | F 323 | | |

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8:25 PM revealed Resident #7 was found by the nursing assistant in floor of her room sitting in front of her wheelchair. Resident #7 was assessed to have "scrape marks on both shoulder blades and below right shoulder blade." The resident denied injury to her head. The nurse's note indicated Resident #7's wheelchair brake was off and Resident #7 was reminded to call for assistance.

An interview with the ADON on 4/20/12 at 3:40 PM revealed she reviewed and did a root cause analysis on each incident. The ADON stated she was aware that Resident #7 had experienced previous falls. She stated she was not informed of the falls Resident #7 experienced on 09/09/11 and 10/16/11. The ADON explained that since she was unaware of both of these falls, no follow up or evaluation was conducted to determine why the resident had fallen and no interventions were attempted to prevent future falls. The ADON indicated when reviewing the fall on 01/11/12 she could not locate any records from the investigation, but from review of the nurse's notes and Falls Committee note, absence of non-skid socks must have been a contributing factor. The ADON further indicated that the fall on 04/15/12 had not been fully investigated.

An interview on 04/20/12 at 4:12 PM with the Director of Nursing (DON) revealed the ADON collected all of the information for the investigation then presented her findings at the daily meeting. The DON confirmed no documentation or Falls Committee note could be located for the falls on 10/16/11 and 04/15/12. The DON specified she expected the ADON to implement pertinent interventions discovered

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| F 323 | Continued From page 28 from the fall investigations and reeducate staff as needed on items such as placing call bell close to resident, placing non-skid socks on residents and monitoring. | F 323 | | |