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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 09/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH CARE CENTER	1736 TODDVILLE RD CHARLOTTE, NC 28214

(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 309 SS=D	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 staff interviews and record review the facility failed to assess a resident's condition after a fall with injury for one (1) of three (3) sampled Residents (Resident #1). The findings are: Resident #1 was readmitted to the facility on 4/24/12 with diagnoses that included dementia, history of CVA and others. The quarterly MDS dated 7/18/12 specified the resident had moderately impaired cognition, required extensive assistance with ADLs and had no falls. Review of Resident #1's medical record revealed a nurses' entry written by licensed nurse (LN) #1 dated 8/21/12 that specified on 8/20/12 at 10:15 p.m. Resident #1 fell from her wheelchair, struck her head on the floor, sustained a laceration above her left eye and was bleeding. The entry specified the on-call physician was notified and ordered the resident to be sent to the Emergency Department for evaluation. The Emergency Department report dated 8/20/12	F 309	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F309 This facility does understand that 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.	10/10/12

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

[signature] on behalf of [illegible], LNHA — ADMINISTRATOR — 9/28/12

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.

original signature
9-27-12 mh

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F 309	Continued From page 1 specified the resident sustained a head injury with a laceration to the forehead that required sutures. Further review of the medical record revealed Resident #1 had no identified wheelchair safety or positioning concerns. Resident #1 had a foam cushion in place for comfort. On 9/19/12 at 11:40 AM LN #1 was interviewed and stated nurse aides were expected to report falls immediately to a licensed nurse. She confirmed she was assigned to care for Resident #1 on 8/20/12 and reported that at 10:15 PM nurse aide (NA) #1 reported Resident #1 fell out of her wheelchair and hit her head on the floor. She stated she went to assess the resident immediately and found the resident in bed with a towel over a one (1) inch long laceration to the forehead bleeding and bruised. LN #1 reported that the resident was transferred from the floor to bed by NA #1. She stated she was not aware of when the resident fell because NA#1 had not notified her immediately after the fall. LN #1 reported she notified the on-call physician and received orders to send Resident #1 to the Emergency Department for evaluation of a head injury. On 9/19/12 at 12:45 PM NA #2 was interviewed and stated that Resident #1 required two (2) people to transfer her. NA #2 added she was trained to report any fall immediately to the licensed nurse on duty. She reported that on 8/20/12 NA #1 came to her and asked her for help with Resident #1. NA #2 stated she entered Resident #1's room and observed the resident in bed with a laceration to the forehead that was bleeding. NA #2 stated NA #1 reported the	F 309	**How the corrective action will be accomplished for the resident(s) affected.** The certified nursing assistant who failed to immediately report the fall is no longer employed by the facility. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Review of August 2012 and September 2012 falls identified no other residents that were transferred prior to notifying the nurse of a fall. **Measures in place to ensure practices will not occur.** Certified nursing assistant staff received education on fall prevention and response; completed by 10/01/12. The Director of Nursing (DON) will review resident falls for staff response by including the nursing team assigned to a resident who experiences a fall in a weekly review of falls for 8 weeks. Any staff found to be deficient in practice will be disciplined using the progressive discipline process.	10/10/12

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F 309	Continued From page 2 resident she fell out of her wheelchair and hit her head on the floor. She added that NA #1 stated she panicked and transferred the resident back to bed and used a towel over the forehead laceration to try to stop the bleeding. NA #2 reported she was unaware of when the resident fell but confirmed NA #1 asked her what to do. NA #2 stated she told NA #1 to notify LN #1 immediately. On 9/19/12 at 1:00 PM NA #1 was interviewed and stated that she was trained to notify the licensed nurse on duty immediately when a resident fell and that she was not to move or reposition a resident until the licensed nurse had assessed the resident for injury. She stated that on 8/20/12 she positioned the wheelchair to the bed, turned away from the resident and during this time the Resident #1 fell out of her wheelchair and hit her head. NA #1 added the resident had a laceration to the forehead that was bleeding. She stated she wasn't sure what to do so she transferred the resident off the floor and back to bed and used a towel to stop the bleeding. NA #1 added she heard NA #2 in a nearby room and asked her for help. NA #1 stated NA #2 told her to notify LN #1. NA #1 was unable to remember how the long she waited before notifying LN #1 that Resident #1 fell. On 9/19/12 at 1:35 PM the Director of Nursing (DON) was interviewed and reported nurse aides were expected to notify the licensed nurse immediately after a resident fell. She stated that NA #1 should not have waited to notify the licensed nurse that Resident #1 fell and should not have transferred the resident back to bed and administered first aide.	F 309	**How the facility plans to monitor and ensure correction is achieved and sustained.** The DON will monitor the fall meetings for eight weeks as indicated above and report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed.	10/10/12

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