

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

NOV 27 2012

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2012
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NAME OF PROVIDER OR SUPPLIER BRIGHTMOOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145
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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
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 observations, staff interviews and medical record reviews the facility failed to update the care plans for fall interventions for two of five sampled residents. Residents # 1 and 4.</p> <p>The findings were:</p> <p>1. Resident #1 was re-admitted to the facility on 3/27/12 with diagnosis of Osteoporosis. Review of the Quarterly Minimum Data Set (MDS) dated 9/4/12 assessed Resident #1 as requiring no assistance for transfers or toileting, and limited</p>	F 280	<p>THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.</p> <p>* F: 280 <u>ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</u></p> <p>A. Resident # 1's care plan was brought before the interdisciplinary team, resident, and nursing staff on 10-31-12 and addressed the issue concerning the motion light and what alarm device was needed in order to help set a reasonable goal, that would help Resident # 1 remain free of accident hazards while helping maintain the highest practicable physical, mental, and psychosocial well being as determined by the resident plan of care.</p> <p>B. Resident # 4's care plan was brought before the interdisciplinary team, resident, and nursing staff on 11-1-12 to address what fall prevention alarms were appropriate for this resident. At that time the care plan was updated and a reasonable goal was set to help Resident # 4 remain free of accident hazards while helping maintain the highest practicable physical, mental, and psychosocial well being as determined by the resident care plan.</p>	11/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Williams TITLE: Adm (X6) DATE: 11-20-12

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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F 280	<p>Continued From page 1</p> <p>assistance for ambulation. This MDS assessed Resident #1 as being continent of bowel and bladder. The resident was assessed as not having behaviors or memory problems.</p> <p>Review of the care plan dated 9/12/12 revealed problems of risks for falls and pathological fractures. The stated goal for this problem included the resident would not have injury from falls thru the next review. Approaches for staff to use to prevent falls included nonskid footwear to be encouraged, monitor for changes in gait, answer calls for help promptly, keep call bell in reach, remind the resident to request assistance, obtain a urinalysis if a fall occurs or she appears to have an unsteady gait and removal of an overlay mattress from the bed. The resident was to lock the brakes on the wheelchair before standing or sitting. The interventions for use of a personal body alarm and the motion sensor lamp were not included on the care plan.</p> <p>Interview on 10/31/12 at 9:50 AM with nurse #4 who updates the care plans revealed she had not updated the use of the motion sensor lamp. The care plan was updated during the interview. This nurse explained it was an oversight, she had missed it. Continued interview revealed Resident #1 was non-compliant with the use of the PBA. Nurse #4 was not aware Resident #1 had an alarm in use. It was not on the care plan due to the information had not been communicated to her.</p> <p>Interview on 10/31/12 at 1:34 PM with administrative staff #1 revealed there was not an order for the PBA. The nurse who had applied the alarm had not written an order, which would</p>	F 280	<p><u>ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:</u></p> <p>On 11-1-12 all residents using alarm devices to assist in preventing accidents were reassessed by the interdisciplinary team, resident, and nursing staff. Each resident was assessed individually and the plan of care was updated to help resident maintain the highest practicable physical, mental, and psychosocial well being. Several alarms were discontinued as the interventions to assist residents in maintaining safety and being free from accidents.</p> <p><u>ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:</u></p> <p>A. As of 11-1-12 any resident who has a fall will be brought before the interdisciplinary team along with the resident, family, and nursing staff to determine the best intervention to assist the resident in maintaining personal safety.</p> <p>B. The MDS Coordinator will update the plan of care and set reasonable goals that will allow the resident to maintain the highest practicable physical, mental, and psychosocial well-being at the time the resident is reassessed before the interdisciplinary team.</p> <p>C. Any alarm devices needing to be ordered or discontinued will be discussed and the MDS Coordinator will be responsible for updating the care plan at the time of discussion. The Administrator will be responsible for monitoring the intervention on the care plan. In the absence of the MDS Coordinator the Director of Nursing will be responsible for updating the care plan.</p>	
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F 280	<p>Continued From page 2</p> <p>have alerted the administrative nursing staff of the new intervention. Continued interview revealed she thought the use of the motion sensor lamp had been included on the care plan.</p> <p>2. Resident #4 was admitted to the facility on 9/7/12 with diagnoses including stroke, abnormal gait, muscle weakness and memory impairment.</p> <p>Review of the annual Minimum Data Set (MDS) dated 8/24/12 revealed Resident #4 was assessed as requiring extensive assistance for transfers and toileting; he did not ambulate and was incontinent of bowel and bladder. Resident #4 had behaviors of being short tempered and memory impairment.</p> <p>Review of the care plan dated 8/24/12 revealed a problem of falls due to unassisted transfers. The stated goal was for Resident #4 not to have injury related to falls. The approaches for staff to take were to keep the half side rails up on both sides of the bed, assist with out of bed transfers, keep the call bell in reach, remind the resident to request assistance, ensure resident wore shoes or non-skid socks, personal alarm to be used at all times and ensure the resident had not removed it, and that the alarm was working. The resident was to remember to lock the brakes on his wheelchair. Nursing staff members were to take Resident #4 to the bathroom on a prompted toileting program. The bathroom door was to have an alarm, a self release belt alarm for the wheelchair; an alarming bed and chair pad were to be used.</p> <p>Review of the physician 's orders revealed an order dated 9/20/12 for use of a low bed with a</p>	F 280	<p><u>INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:</u></p> <p>The Director of Nursing, Clinical Service Nurse and MDS Nurse have a QA's alarm form and are required to monitor if the correct alarm device is on, placement, and functioning of the device on a daily basis.</p> <p>On a weekly basis the alarm form will be brought before the weekly QA Committee and compared to the care plan. At that time the QA Committee will be responsible for making sure the current intervention plan is working or implement a new one if it is determined that the current intervention is not adequately addressing the alleged deficient practice. A consultant RN has been secured to evaluate the QA system for falls and interventions to assist in prevention of accidents. She will also observe the actual QA by the nursing staff for adequacy and accurateness weekly for 4 week and will present her findings to the Administrator and QA Committee.</p> <p>These audits will also be reviewed by the facility administrator within 24 hours of completion and by the QA Committee monthly to ensure that corrections are achieved and sustained.</p>	

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F 280	Continued From page 3 mat on the floor. Each shift was to check and initial the interventions were in place. Observations on 10/30/12 at 1:50 PM revealed Resident #4 did not have a mat on the floor, and the bathroom door did not have an alarm installed. Interview on 10/31/12 at 9:50 AM with Nurse #4 who updates the care plans revealed she was not aware the bathroom door alarm had not been initiated. The administrator was aware of the intervention, and would have requested the maintenance staff to install the alarm. The date the bathroom door alarm was implemented according to the care plan was 9/24/12. Nurse #4 could not explain how the intervention had been missed. Continued interview revealed she was not sure if a floor mat was in use as an intervention. The care plan was reviewed with this staff member, and the bathroom door alarm was on the current care plan. The floor mat was not on the care plan. Interview on 10/31/12 at 1:34 PM with administrative staff #1 revealed she could provide an answer as to why the bathroom door alarm was not installed. This staff member explained Resident #4 was supposed to have a mat on the floor any time he was in the bed. The intervention of a floor mat should have been on the current care plan.	F 280			
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	F 323	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.		11/9/12

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F 323	<p>Continued From page 4</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews the facility failed to ensure interventions to prevent falls were in place for three (3) of five (5) sampled residents. Residents # 2, 3, and 4.</p> <p>The findings were:</p> <p>1. Resident #4 was admitted to the facility on 9/7/12 with diagnoses including stroke, abnormal gait, muscle weakness and memory impairment.</p> <p>Review of the annual Minimum Data Set (MDS) dated 8/24/12 revealed Resident #4 was assessed as requiring extensive assistance for transfers and toileting, he did not ambulate and was incontinent of bowel and bladder. Resident #4 had behaviors of being short tempered and memory impairment. The Brief Interview for Memory Score (BIMS) was not coded due to Resident #4 rarely was understood. The interview was not conducted for this MDS. The annual MDS assessed the resident has having long term memory problems. The resident had moderate impairment in decision making and required cues and/or supervision for decision making.</p> <p>Review of the care plan dated 8/24/12 revealed a problem of falls due to unassisted transfers. The</p>	F 323	<p>* F: 323</p> <p><u>ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</u></p> <p>All nursing staff was re educated on November 1st and 2nd 2012 by the Director of Nursing to ensure that each resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p><u>ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:</u></p> <p>All nursing staff was in-serviced on November 9, 2012 by the Director of Nursing regarding alarm devices, low beds with mats, wander guards, and any devices put into place to prevent falls. At that time it was explained to the certified nursing assistant's that they are responsible for making sure the residents on their assignment have any alarm devices turned on, properly placed, and in working order. Also nurses were educated any time a fall occurs the Administrative on call nurse must be made aware to make sure the appropriate intervention is in place and communicated to the MDS Coordinator so the care plan can be updated.</p>	

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F 323	<p>Continued From page 5</p> <p>stated goal was for Resident #4 not to have injury related to falls. The approaches for staff to take were to keep the half side rails up on both sides of the bed, assist with out of bed transfers, keep the call bell in reach, remind the resident to request assistance, ensure resident wore shoes or non-skid socks, personal alarm to be used at all times and ensure the resident had not removed it, and that the alarm was working. The resident was to remember to lock the brakes on his wheelchair. Nursing staff members were to take Resident #4 to the bathroom on a prompted toileting program. The bathroom door was to have an alarm, a self release belt alarm for the wheelchair, an alarming bed and chair pad were to be used.</p> <p>Review of the nurses' notes dated 9/20/12 at 1:45 PM revealed Resident #4 had fallen taking himself to the bathroom unassisted. The notes stated the resident had been in bed after lunch, the alarms were intact and working. No injuries from this fall.</p> <p>Review of the physician orders dated 9/20/12 revealed an order for the bed, chair, and self release alarms, and a floor mat for use beside the bed at all times.</p> <p>Review of the nurses' notes dated 10/19/12 at 6:55 AM revealed the resident was sitting in the bathroom floor. Recorded interview with Resident #4 by the nurse revealed he stated he had to go to the bathroom. No injuries were noted from the fall.</p> <p>Observations on 10/30/12 at 10:06 AM, 1:45 PM and 3:52 PM revealed no mat was on the floor</p>	F 323	<p>A. On 11-1-12 all residents using alarm devices to assist in preventing accidents were reassessed by the interdisciplinary team, resident, family and nursing staff.</p> <p>Each resident was assessed individually and the plan of care was updated to help resident maintain the highest practicable physical, mental, and psychosocial well-being. Several alarms were discontinued that no longer assisted the resident in maintaining an environment free from accidents.</p> <p>B. A new certified nursing assistant daily schedule was created with each resident's name and what alarm device, low bed with mat, and wander guard the resident is care planned to have. The Clinical Service Supervisor is responsible for updating this form as the intervention/care plan changes.</p> <p>Nursing staff is aware any discrepancies noted on this form must be immediately reported to the on call administrative person. Failure to do will result in disciplinary action.</p>	

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F 323	<p>Continued From page 6</p> <p>beside the bed. There were three alarm boxes on the right side of the bed frame.</p> <p>Observations on 10/30/12 at 1:45 PM revealed Resident #4 was sitting on the side of the bed with his feet dangling. He was sitting at the foot of the bed between the footboard and the side rail. He had regular socks on both feet, and not the non skid socks. No alarms were sounding. An interview with Resident #4 was attempted at that time. The resident had expressive aphasia due to the stroke and his answers were not clear.</p> <p>On 10/30/12 at 1:49 PM nurse #3 came to the room. The resident adjusted himself back up in the bed. An interview occurred with nurse #3 with explanations of what each alarm box was and how it worked. Nurse #3 removed one of the three alarms as it was not needed, and did not work. She explained if the resident " wiggled in bed " the bed alarm would sound. She also explained Resident #4 wanted to be independent, and would not wait for assistance of staff. During this interview, nurse #3 explained the resident would remove the PBA and was noncompliant with its use. The PBA was found in the bed, and was applied to Resident #4 ' s shirt in the back. This nurse had no explanation as to why the alarms had not sounded.</p> <p>Review of the e-mar with nurse #3 revealed all of the alarms were on the hand held computer used to document on the e-MAR (electronic Medication Administration Record). Review of the e-mar revealed the floor mat was not on the computer. Nurse #3 was not aware of the use of a mat on the floor. No explanation was given for the mat not being on the e-MAR</p>	F 323	<p><u>ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:</u></p> <p>A. On 11-1-12 all residents using alarm devices to assist in to prevention of accidents were reassessed by the inter disciplinary team, resident, family and nursing staff. Each resident was assessed individually and their plan of care was updated to help resident maintain the highest practicable physical, mental, and psychosocial well-being. Several alarms were discontinued that no longer assisted the resident in maintaining free from accidents and environment.</p> <p>B. A new certified nursing assistant daily schedule was created with each resident's name, what alarm device, low bed with mat, and wander guard the resident is designated to have. The Clinical Service Supervisor is responsible for updating this form as needed. Nursing staff is aware any discrepancies noted on this form must be immediately reported to the on call administrative person. Failure to do will result in disciplinary action.</p>	
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F 323	Continued From page 7 Interview on 10/31/12 at 9:04 AM with aide # 3 revealed Resident #4 has a floor mat. Aide #4 was asked if she used the mat on her shift, she stated it was for 11-7 shift when the resident is in bed at night. Continued interview revealed Resident #4 can ask for help if he needs assistance. Interview on 10/31/12 at 9:50 AM with the MDS nurse revealed Resident #4 should have non-skid socks on when not wearing shoes. He was independent with transfers and took himself to the bathroom. It was further explained Resident #4 would not use the call bell for assistance. The most recent intervention was the change in the wheelchair alarm on 10/26/12. When asked about the approach for the bathroom door alarm, the MDS nurse was not aware if it was in use. The administrator would have to answer if it had been provided. The care plan was reviewed with the MDS nurse as to the date of 9/24/12 for the implementation of the bathroom door alarm. The response provided was she did not know how that was missed. When the MDS nurse was asked about the use of the floor mat, she did not know if a floor mat was to be used, as it was not on the care plan. Interview on 10/31/12 at 12:00 PM with administrative staff #1 revealed Resident #4 was supposed to have a mat on the floor by the low bed. No reason could be provided as to why it was not being used. Administrative staff #1 was not aware of the alarm needed for the bathroom door for Resident #4. The addition of a personal alarm for Resident #3 in the Wanderguard/PBA notebook must have been an oversight.	F 323	<u>INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:</u> The Director of Nursing, Clinical Service Nurse and MDS Nurse have a QA's alarm form to monitor if the correct alarm device is on, placement, and functioning of the device on a daily basis. On a weekly basis the alarm form will be brought before the weekly QA and compared to the care plan. At that time the QA will be responsible for making sure the current intervention plan is working or implement a new one if it is determined that the current intervention is not adequately addressing the alleged deficient practice. A consultant RN has been secured to evaluate the QA system for falls and interventions to assist in prevention of accidents. She will also observe the actual QA by the nursing staff for adequacy and accurateness weekly for 4 week and will present her findings to the Administrator and QA Committee. These audits will also be reviewed by the facility administrator within 24 hours of completion and by the QA Committee monthly to ensure that corrections are achieved and sustained.	

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F 323	<p>Continued From page 8</p> <p>2. Resident #3 was admitted to the facility on 6/29/09 with diagnoses including end stage Alzheimer ' s, Dementia and muscle weakness.</p> <p>Review of the annual Minimum Data Set (MDS) dated 9/17/12 revealed Resident #3 required extensive assistance of two staff for toileting and transfers, she did not ambulate and was incontinent of bowel and bladder. Resident #3 was assessed as having short and long term memory problems with a Brief Interview for Memory Score (BIMs) of 6.</p> <p>Review of the care plan dated 10/2/12 revealed a problem of at risk for falls. The stated goal for this problem was for Resident #3 not to have any injuries from falls. The approaches for staff included medications per MD (medical doctor), answer calls for help promptly, assess ability to ambulate, assist of one or two staff for transfers, call bell in reach, shoes or non-skid socks for transfers and personal body alarm (PBA) on at all times.</p> <p>Review of the nurses ' notes dated 9/17/12 at 9:05 AM revealed Resident #3 was found on the floor of her room. Staff documented the resident stated she had " slid out of chair. " There were no injuries that occurred from the fall.</p> <p>Review of the physician ' s order dated 9/18/12 revealed a PBA was to be worn at all times. This was the intervention after a fall occurred on 9/17/12.</p> <p>Review of the notebook for wanderguard and PBA (personal body alarms) checks to be</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2012
NAME OF PROVIDER OR SUPPLIER BRIGHTMOOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	
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F 323	<p>Continued From page 9</p> <p>completed by staff did not list Resident #3 as having an alarm.</p> <p>Observations on 10/30/12 at 10:15 AM, 12:25 PM and 4:00 PM revealed Resident #3 did not have the alarm in use while sitting in the wheelchair.</p> <p>Interview on 10/30/12 with nurse #1 at 4:02 PM revealed the nurses know which residents have alarms/floor mats. Documentation would be completed on the e-mar when they were checked by the nurses. The nurse could also document in the nurses' notes the alarm or floor mats are in place. Further interview revealed the restorative aide was an additional check for the alarms using the notebook that contained the wanderguards and PBAs.</p> <p>Observations on 10/31/12 at 9:05 AM revealed Resident #3 was seated in her wheelchair and did not have the alarm.</p> <p>Interview on 10/31/12 with aide #3 at 9:08 AM revealed interventions for fall prevention for Resident #3 included using a PBA, which was a small alarm box with a magnet attached to a clip. Interview with aide #3 revealed she had taken care of Resident #3 on 10/30/12 on the 7-3 shift. She as not aware Resident #3 did not have the alarm. Further explanation was provided, that all staff work together as a team. She had not transferred Resident #3 to her chair that morning. The aide that had gotten her up and sat her in the wheelchair would have applied the alarm. Upon inspection with aide #3 the alarm was not on the resident.</p> <p>Interview on 10/31/12 with aide # 5 at 9:20 AM</p>	F 323		

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F 323	<p>Continued From page 10</p> <p>revealed Resident #3 had a PBA in use and her call bell was to be in reach for fall prevention. Upon inspection with aide #5 the alarm was not on the resident.</p> <p>Interview on 10/31/12 with aide # 3 at 9:30 AM revealed after our interview, she looked for the PBA to apply to Resident #3. She had found the alarm inside the bedside stand. The battery was dead and she was looking for another alarm to attach to Resident #3. A functioning alarm was found, and given to the restorative aide to apply to Resident #3.</p> <p>Interview on 10/31/12 at 9:35 AM with the restorative aide revealed she checks residents each day for the presence of the alarm and that it is working. She has a notebook that she documents the alarms are checked each day. Her process of checking alarms was to observe the residents on a random basis, throughout the day. She would check for the presence of the alarms, check for functioning of the alarm, and then document on the check list in the notebook. When asked if Resident #3 was checked on 10/30/12 she replied " yes, checked Resident #3 and she had an alarm. She could not remember the time it was checked.</p> <p>Interview on 10/31/12 at 12:00 PM with administrative staff #1 revealed the aide was to ensure the alarm was on the resident, the nurse would document on the e-mar and check to see if it was working and the final check was by the restorative aide. The checks were to be done each day.</p> <p>Interview on 10/31/12 at 12:05 PM with</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER BRIGHTMOOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145
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F 323	<p>Continued From page 11</p> <p>administrative staff #2 revealed she performed the review of the wanderguard/PBA notebook to ensure the checks were completed by the restorative aide. It was her expectation the restorative aide would take the notebook and make rounds to check the presence of the alarms and if the alarms were functioning. No explanation was provided for Resident #3 not having a sheet for the PBA check by the restorative nurse assistant.</p> <p>Copies of the electronic medication administration record were provided on 10/31/12 at 2:00 PM for Resident #3. Review of the order for the " PBA on at all times to alert staff if resident attempting to get up unassisted " was initialed by nurses on the 7-3 shift and 3-11 shift for the date of 10/30/12.</p> <p>3. Resident #2 was admitted to the facility on 4/1/11 with diagnoses of Dementia, Parkinson ' s, Diabetes and Hypertension.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 8/20/12 assessed Resident #2 as requiring extensive assistance with toileting, did not ambulate and could transfer independently. Resident #2 was continent of bladder and frequently incontinent of bowel. This MDS did not record any behaviors as occurring and had memory impairment. The Brief Interview for Memory Status (BIMS) on the quarterly MDS showed an impairment of short and long term memory. The score was a 7.</p> <p>Review of the care plan dated 8/21/12 revealed a problem of being at risk for falls. The stated goal</p>	F 323		

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F 323	<p>Continued From page 12</p> <p>for this problem was for the resident to have no injuries related to falls. The approaches for staff to use for fall prevention included answering the calls for help, assess her ability to ambulate safely with a rolling walker and staff assistance, encourage her to wear shoes or non-skid socks, keep the bed a the lowest level, therapy to evaluate and treat and use a personal body alarm (PBA).</p> <p>Review of the nurses ' note revealed Resident #2 had a fall on 10/25/12. Nursing staff had taken Resident #2 to the bathroom. The wheelchair had slipped and the resident fell. A skin tear occurred on the right arm, bruising on the upper extremity and a hip strain. The resident was sent to the emergency room because the nursing staff were not sure if she had hit her head. Interventions for this fall were for therapy to evaluate and treat as indicated.</p> <p>Review of the nurses ' note revealed Resident #2 had a fall on 10/28/12. She had fallen while self transferring from the wheelchair to the bed. Resident #2 was observed on the floor on her knees, had fallen forward and hit her head. A quarter size hematoma was noted on the left forehead. Resident #2 was transferred to the emergency room for evaluation. The intervention for this fall was for a personal body alarm (PBA) to be on at all times.</p> <p>Observations on 10/30/12 at 10:18 AM revealed Resident #2 was in a wheelchair, self propelling down the hall of the facility. The PBA was held in her right hand, not attached to her clothing or the wheelchair. The resident was asked what she had in her hand, and she replied it was to keep</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>her from falling. After traveling down one hallway, and onto the next hallway, a nurse stopped and applied the alarm to the wheelchair and the resident.</p> <p>Observations on 10/31/12 at 8:46 AM revealed Resident #2 was in bed, the PBA was attached to the resident by the clip, and the alarm box was on top of the pillow. The alarm was not clipped to any part of the bed to hold it in place.</p> <p>Interview on 10/31/12 at 9:08 AM with aide #3 revealed the alarm was attached to Resident #2, but should have been clipped to her pillow. If Resident #2 had attempted to get out of bed, it would then alarm by the magnet coming loose from the box. Further interview revealed Resident #2 would remove the alarm herself. This aide was asked how the staff would monitor if Resident #2 had the alarm attached. Her response was, the resident would come up to us (staff) and ask to have it put back on.</p> <p>Interview on 10/31/12 at 9:50 AM with the MDS nurse revealed Resident #2 had an intervention to prevent falls of use of an alarm that was attached to her at all times. Therapy had been ordered for the resident, but she was not aware if Resident #2 was on their caseload. When asked if the alarm was working as an intervention, she replied yes, so far. The resident does take it off and play with it. The staff have to monitor that it is in place and working. Further interview revealed Resident #2 had auditory hallucinations and thought the alarm was talking to her, and would remove it.</p>	F 323			