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
	345415	A. BUILDING _____ B. WING _____	C 08/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

(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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to implement the care plan intervention (an alarm) for 1 of 4 sampled residents for accidents. (Resident #4) The findings include: Resident #4 was admitted 09/02/11 with diagnoses of right below the knee amputation, blindness and anxiety. A minimum data set dated 07/27/13 indicated Resident #4's cognition was intact, required extensive assist with toileting and transfers and was a fall risk with a fall history. A review of Resident #4's nurse's note dated 07/21/13 revealed the resident was found on the floor in the bathroom after attempting to transfer from the wheelchair to the toilet. The note indicated no injury. Review of an interdisciplinary team note dated 07/22/13 revealed Resident #4 had been reminded several times to use his call bell for assistance when toileting. The note specified a new intervention of a pressure pad alarm in the chair and bed at all times for safety precaution	F 323	Pineville Rehab & Living Center F 323 It is the policy of Pineville Rehabilitation & Living Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents The deficient practice in relation to resident #4 has been identified and reviewed by facility staff. Facility staff placed a pad alarm in chair / bed for safety precautions due to resident #4 being at risk for fall. Facility staff ensured this device was placed on residents care plan, care guide and MAR. A 100% audit was conducted by facility staff ensuring that all other residents that have been identified for being at risk for fall have the proper interventions in place. The audit revealed that all interventions are in place, care planned, listed on the residents care guide and are listed on the MAR . All interventions that have been implemented by the facility for residents who are at risk for falls are placed on the MAR. Nursing staff will be responsible for signing the MAR and ensuring the interventions are in place and properly functioning on a daily basis. In addition, an audit tool has been created and implemented to identify the following: Fall equipment is in place, the MAR reflects fall equipment ordered, resident care plan reflects fall equipment ordered and that care guides reflect fall equipment ordered. Nursing staff will be educated regarding reviewing the MAR and care guides on a daily basis to ensure proper fall equipment is in place and properly functioning.	9/9/2013

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

ADMINISTRATOR 8/29/13

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.

DHSR/CO Black Mountain/WRO Received AUG 30 2013 by: PAM

Original signature date 8-26-13mh

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F 323	Continued From page 1 due to unassisted transfer attempts. A physician order dated 07/22/13 indicated a pressure pad motion alarm when in bed or chair for safety due to unassisted transfer attempts and to check every shift for placement and function. During an observation of Resident #4 on 08/13/13 at 8:52 AM, Resident #4 was in the dining room eating breakfast in his wheelchair with no alarm attached to his wheelchair. During an observation of Resident #4 on 08/13/13 at 9:27 AM, Resident #4 noted in hallway by nurse's medication cart with eyes closed and no alarm to wheelchair. During an interview with Nurse Aide (NA) #1 on 08/13/13 at 10:30 AM, NA #1 explained Resident #4 required more assistance with transfers due to his recent falls, blindness and his prosthetic leg. NA #1 also explained due to the falls an alarm to the bed and chair had been added. On 08/13/13 at 1:45 PM an observation of Resident #4 was made. Resident #4 was in hallway across from the main entrance corridor in a wheelchair with no alarm noted to wheelchair. Resident #4 attempted to go to his room and was entering another resident's room when NA #1 offered assistance to push him to his room. On 08/13/13 at 1:49 PM when NA #1 was asked if Resident #4 should have an alarm to the chair, NA#1 responded she did not get him up but he should have one on his chair. NA #1 began to search the resident dresser draws and the bed but did not find an alarm. NA #1 exited the room and announced she had to inform the nurse.	F 323	All interventions that have been implemented by the facility for residents who are at risk for falls are placed on the MAR. Nursing staff will be responsible for signing the MAR and ensuring the interventions are in place and properly functioning on a daily basis. An audit tool has been created and implemented to identify the following: Fall equipment is in place, the MAR reflects fall equipment ordered, resident care plan reflects fall equipment ordered and that care guides reflect fall equipment ordered. This audit tool will be conducted weekly for four weeks, then monthly for six months, and then quarterly thereafter. The QA committee will review each QA tool as they are completed. Any discrepancies noted will be documented and further action will occur as directed by the QA committee. Audit results will also be brought to the QA meeting for discussion and review on a quarterly basis by the facility Administrator.	

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F 323	Continued From page 2 During an interview with the Assistant Director of Nursing (ADON) on 08/13/13 at 1:52 PM, the ADON explained Resident #4 had four falls in the month of July, two of which he sustained lacerations and was sent to the emergency room. The ADON added that even though Resident #4 was alert and oriented he was blind and a sensor alarm was added at the time of his last fall due to his continued noncompliance with asking for help. During an interview with Resident #4 on 08/13/13 at 2:15 PM, Resident #4 was observed with no sensor alarm to his wheelchair. During the interview Resident #4 explained he had fallen once from his bed, twice from the toilet and sustained some cuts and bruises due to transferring without using his prosthetic leg. Resident #4 also added he never removed the alarm and did not have a problem with having the alarm on the chair.. Interview with the Nurse # 2 on 08/13/13 at 2:54 PM revealed she was made aware that the sensor alarm was not on Resident #4 and went to the activity he was attending to ask his permission to place the alarm. Nurse # 2 explained she was on her way to the room to get the alarm as Resident #4 stated it was okay to apply the alarm during the activity. Nurse #2 confirmed the alarm should have been placed on the chair earlier and was a part of the resident's orders. During an interview with Nurse #1 on 08/13/13 at 2:56 PM, the Nurse stated she did not see Resident #4 before he went for breakfast in the morning and did not notice whether he had his alarm on or not throughout the day. Nurse # 1	F 323		

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F 323	Continued From page 3 also added the alarm was on the medication administration record and when she had gone to the room to check for the alarm prior to the end of her shift she observed the alarm on the bed not on the resident. A follow up interview with the ADON was conducted on 08/13/13 at 3:12 PM. The ADON explained she expected the nurse to have checked the alarm for placement and function whether the resident was in the bed or in the chair and to ensure the alarm was in place. The ADON added it was not acceptable for the nurse to wait until the end of her shift to realize the alarm was not on the resident. The ADON also stated the alarm is a safety precaution and serves no purpose for the resident if it is not in place. During an interview with the Administrator on 08/13/13 at 3:25 PM, the Administrator stated the expectation was for implemented interventions to be followed and that should not have to wait until 2:45 PM or 3:00PM.	F 323		