

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345258</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE:  <b>6/12/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TRANSITIONAL HEALTH SERVICES OF KANNAPO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 CONCORD LAKE ROAD KANNAPOLIS, NC</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 282</b>	<p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to follow the care plan for falls by not using a mat on the floor as directed by the physician ' s order and care plan for one of three residents reviewed for accidents (Resident #59). The findings included:</p> <p>Resident # 59 was admitted to the facility 3/8/13 and last readmitted to the facility 2/6/14. Cumulative diagnoses included: peripheral vascular disease, depression, dementia, COPD (chronic obstructive pulmonary disease), anticoagulant therapy and history of squamous cell carcinoma.</p> <p>A Quarterly Minimum Data Assessment (MDS) dated 5/16/14 indicated Resident #59 was moderately impaired in cognition. He required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toileting and personal hygiene. Ambulation did not occur during the assessment period. Balance was impaired and Resident #59 was only able to stabilize with staff assistance from moving from a seated to standing position, moving on and off the toilet and surface to surface transfer. Range of motion was impaired on one side of the lower extremity. No falls were noted since admission/ last assessment.</p> <p>Physician ' s orders for June, 2014 were reviewed and included the following orders originally dated 2/6/14: mat beside bed; keep bed in lowest position at all times.</p> <p>A review of the medical record revealed Resident #59 sustained a fall on 6/6/14 that resulted in a laceration of the forehead requiring stitches. Interventions implemented after the fall included: offer to lie down after lunch. Fall committee review/ recommendations also included: sensor pad to wheelchair.</p> <p>A physician ' s order dated 6/10/14 stated: sensor alarm to wheelchair to alert staff of unsafe movements.</p> <p>Care plan dated 7/6/13 and last reviewed on 6/9/14 indicated Resident #59 was at risk for falls due to generalized weakness, poor safety awareness, balance/gait deficits and medication regimen. Approaches included, in part, optimal monitoring of resident while in bed and up in chair; monitor resident for episodes of restlessness, increased agitation, anxiety; keep items resident frequently used within close, easy reach and in routine placement--call light accessible at all times, bed in low position, SR (side rails) x 2. Assist with all transfers and toileting to aid in safety and balance. Mat beside bed per physician order. Low bed as needed. On 6/9/14 Sensor alarm to wheelchair to alert staff to unsafe movements was added to the approaches.</p> <p>On 6/9/14 at 3:00PM, Resident #59 was observed sleeping in bed. Bed was in low position with the right side of the bed next to the wall. There was no mat on the floor on the left side of the bed.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 282</b>	<p>Continued From Page 1</p> <p>On 6/9/14 at 4:30PM, Resident was observed sleeping in the bed. There was no mat on the floor on the left side of the bed.</p> <p>An interview was conducted with Resident #59 on 6/10/14 at 10:23AM. Resident #59 was sitting in the wheelchair. Observations of the room and bathroom revealed there was not a floor mat in the room.</p> <p>On 6/11/14 at 12:05PM, Nurse #1 stated Resident #59 was alert and usually used his call bell or call out when he needed assistance. She stated he did not have a history of falls and, to her knowledge, the fall on 6/6/14 was his first fall. Nurse #1 stated staff placed his bed in the lowest position when he was in bed, checked on frequently and offered to assist him to bed/ provide his needs. She also stated he had a sensor alarm pad for his bed and his wheelchair.</p> <p>An observation was conducted on 6/11/14 at 12:05PM. Resident #59 was lying in bed. There was no mat on the floor on the left had side of the bed. A sensor pad was in place in bed and functioned properly.</p> <p>On 6/11/14 at 5:01PM, NA (nursing assistant) #1 stated she provided care for Resident #59 during the evening shift. She stated she had been employed at the facility approximately four months. NA #1 stated she made sure his bed was in the low position when he was in bed. Staff also used a sensor alarm pad on his chair and for his bed when he was in the bed. She stated Resident #59 did not have a mat on the floor. NA #1 said they had a mat on the floor but it was removed a couple of months ago.</p> <p>On 6/11/14 at 5:18PM, Administrative staff #2 stated she had not seen a mat being used since she had been in the facility. She reviewed the care plan and physician ' s orders and stated she expected staff to use a mat for Resident #59 because there was a physician ' s order for the mat on the floor and was in the care plan also.</p>		