STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

(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, staff and resident interviews and review of the medical record, the facility failed to determine the cause of a fall and place interventions after falls for 1 of 3 residents (Resident # 3) that was reviewed for falls. Findings included: Resident #3 was admitted on 5/13/13 with diagnoses that included peripheral vascular disease, Alzheimer's disease, hypertension, joint pain and generalized muscle weakness. Progress notes for 4/22/14 at 3:53 AM, indicated the resident was sitting on the floor in front of her wheelchair. She stated she was trying to go to the bathroom. The note indicated non-skid socks were in place and the call light was on the bed. The intervention used was to reinforce the use of the call bell. The Annual Minimum Data Set (MDS), dated 5/6/14, indicated the resident had severe cognitive impairment, scoring 0 on her Brief Interview for Mental Status (BIMS). The MDS indicated the resident required limited assistance	F 323	Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the conclusions stated on the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely because of requirements under State and Federal Law. For the resident affected: Due to resident□s increased confusion and behaviors reported by the State Surveyor, Nurse #1 and the NA, a UA/C&S was done immediately. Side rail pads were also added to side rails in an effort to prevent Resident #3□s limbs from getting caught in railing. The preliminary results returned on 8/15/2014 which appeared to be showing a probable UTI. The MD ordered Cipro HCl mg BID x 7 days. On 8/20/2014, the complete UA/C&S results were received and revealed Resident # 3 had E. Coli UTI. MD was made aware and reviewed results. MD ordered Cipro to be discontinued and a new order for Rosephin 1gm/ vial injection solution QD x	9/11/14

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

Electronically Signed | 08/21/2014

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F 323	Continued From page 1 with transfers. There had been one fall since the prior assessment. Review of Resident # 3's care plan indicated falls was identified as a focus area on 05/13/13. Goals listed to assist the resident in having no falls included the use of proper and non-skid footwear when out of bed, a flat call bell and total lift for transfers. There was no documentation on the care plan that indicated new interventions were added after the April 2014 fall. An observation was made on 8/14/14 at 9:15 AM. Resident # 3 was observed in bed with the side rails up. The resident was lying cross-wise the bed with her head over the rail closest to the door and her feet over the opposite rail. The bed was in a high position. Nurse # 1 was requested to intervene to keep the resident from falling. Nurse # 1 and a nursing assistant (NA) repositioned the resident in bed. Resident # 3 was observed on 8/14/14 at 1:46 PM. The resident was sitting in the wheelchair with the flat call bell placed on the bed. The resident was unable to locate the call bell and reached down to the floor when asked to find the bell. NA # 1 was interviewed on 8/14/14 at 1:58 PM. She stated she was familiar with Resident # 3. The NA stated Resident # 3 was at risk for falls. Interventions identified by the NA for fall prevention included moving the wheelchair away from the bed so the resident would not try to get up, peek in the room when walking by the room and getting her up if she was agitated. The NA stated prior to this morning she had not seen the resident hanging over the rails, adding the	F 323	7 days was received by MD. For the residents with the potential to be affected: All licensed nurses were re-educated on the Fall Prevention Program Policy with emphasis placed on the importance of completing the Fall Investigation Report immediately. All staff members were also in-serviced on a new procedure put in place to prevent falls from being missed. This procedure requires all licensed nurses to call the ADON after every fall that occurs on their hall. This protocol will allow the ADON to ensure a sensible and affective intervention has been put in to place immediately. Measures put in to place: All licensed nurses were re-educated on the Fall Prevention Program Policy with emphasis placed on the importance of completing the Fall Investigation Report immediately. All staff members were also in-serviced on a new procedure put in place to prevent falls from being missed. This procedure requires all licensed nurses to call the ADON after every fall that occurs on their hall. This protocol will allow the ADON to ensure a sensible and affective intervention has been put in to place immediately. Monitoring: To ensure the facility remains in compliance, the Administrator, DON or designee will run a Progress Notes Report and audit all notes typed in the previous 24 hours to ensure that an event investigation report has been completed for every fall that is mentioned in the notes. This audit will be performed daily for the previous 24 hours x 1 month. If no	

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F 323	Continued From page 2 resident was more agitated than usual today. On 8/14/14 at 2:09 PM, Nurse # 2 was interviewed. Nurse # 2 was the lead nurse for B hall and stated he was familiar with Resident # 3. Nurse #2 stated Resident # 3 was alert and oriented to family only and was unable to remember instructions. He stated you could instruct her on calling for help prior to getting up, the resident would be able to verbalize and may even understand, but she would be unable to recall that information. Nurse # 2 was unaware of the April 2014 fall, but was aware the resident had previous falls. Nurse # 2 stated the expectation was for the nurse on duty to place immediate interventions at the time a resident fell. The nurse would also be expected to communicate the fall and intervention to the on-coming nurse as well as add it to the 24 hour report. Nurse # 1 was interviewed on 8/14/14 at 3:04 PM. She stated she was not familiar with Resident # 3. The nurse stated when she entered Resident # 3's room this morning she was lying across the bed with her head on the rail and her feet hanging off the other side. Nurse # 1 added she and a NA repositioned the resident. The Assistant Director of Nursing (ADON) was interviewed on 8/14/14 at 3:11 PM. She stated when a resident fell it was the expectation for the nurse to assess the resident. If there were no injuries, the expectation would be for all staff involved to discuss what happened to determine the cause of the fall. The nurse on duty would be expected to place an immediate intervention. The ADON was unsure if it were facility policy to complete an Event Investigation report, adding the fall could be identified by an ALERT note.	F 323	areas of concern are found, the audit will then be reduced to weekly x 3 months. Any areas of concern will be discussed in the quarterly Quality Assurance Meeting and addressed accordingly.	

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F 323	Continued From page 3	F 323		

The ADON reviewed the progress note for the April 2014 fall and acknowledged there was no Event Investigation or new intervention for this fall. The ADON added with a score of 0 on the BIMS, education and reminders would not be an appropriate intervention for Resident # 3.

On 8/14/14 at 3:43 PM, the Administrator was interviewed. She stated it was the facility policy to complete an Event Investigation and initiate immediate interventions after each resident fall. The Administrator reviewed the progress notes and the care plan for Resident # 3 and acknowledged there were no new interventions added. She acknowledged an Event Investigation had not been completed for the April 2014 fall. The Administrator stated since the Event Investigation had not been completed, there was no trigger for the fall, and therefore, no intervention had been added.

The Director of Nursing (DON) was interviewed on 8/14/14 at 4:37 PM. She stated it was the facility policy to complete an Event Investigation after a resident fall. This was important, she added, in tracking and trending falls to determine the root cause of the fall. The expectation would be for the nurse on duty to add a new intervention at the time of the fall. The DON acknowledged there was no Event Investigation and intervention added for Resident # 3's April 2014 fall. She added with a BIMS score of 0, Resident # 3 could not be educated or reminded to call for assistance.