STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. BUILDING _____ B. WING _____	C 07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE WELLNESS CTR	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

(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=G	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 observations, record review and staff interviews the facility failed to provide supervision of a resident seated on a shower chair which resulted in a fall and did not utilize a mechanical lift to transfer a resident for 1 of 3 residents reviewed for accidents (Resident #6). The findings included: Resident #6 was admitted to the facility on 10/31/02 with diagnoses of heart failure, cerebral vascular accident, hemiplegia and Alzheimer's disease. A review of the Minimum Data Set (MDS) dated 05/22/14 revealed Resident #6 was severely impaired in cognitive skills for daily decision making. The MDS further revealed Resident #6 had a history of falls was totally dependent for transfers and bathing. A review of the care plan dated 05/16/14 revealed Resident #6 had a history of falls and was at risk for further falls with the potential for injury. The goal indicated Resident #6 would have no avoidable injury related to falls through the next review dated 08/29/14 and the interventions included in part to anticipate and meet resident's needs as much as possible, keep Resident #6 within eyesight and within arm's reach at all times when in the shower and the use of a mechanical	F 323	The facility does ensure that the resident□s environment remains as free of accident hazards as is possible and each resident receives the adequate supervision and assistance devices to prevent accidents. R6 has had no further negative outcome from her fall on 6/19/2014. Both Certified Aides involved in the improper transfer have been terminated from employment from this facility. All other residents will be evaluated and determinations made by members of the IDT on the type of transfer they require. All residents will be provided adequate supervision needed during showering to ensure compliance with this requirement. The following measurements have been put in place to ensure compliance: 1. 100% audit has been done on all residents to determine their individual transfer status. These determinations will be reflected in the resident□s care plan. 2. All residents will be provided close supervision while in the shower. This will include not leaving resident unattended in	8/15/14

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

Electronically Signed | 08/08/2014

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 323	Continued From page 1 lift for all transfers. A review of the nurse's notes dated 06/20/14 revealed Nurse #1 was called to the shower room on the 300 hall at 9:45 PM and Resident #6 was observed lying in the floor on her right side. The notes revealed NA #1 stepped away from Resident #6 to pick up towels and the resident fell out of the shower chair. Resident #6 was observed to have a laceration over her left eyebrow measuring approximately 1.5 centimeters and three skin tears to the left elbow. The notes further indicated Resident #6 showed increased agitation and the on-call physician was notified and ordered the resident to be sent to the emergency room for evaluation and treatment. Review of the facility incident report dated 06/20/14 revealed Nurse #1 was called to the shower room and observed Resident #6 lying on her left side with a laceration above her left eyebrow and three skin tears to her left arm. The report indicated Resident #6 was oriented to person with complaints of pain to her left hip and above her left eyebrow. The report also indicated Resident #6's fall was witnessed by NA #1 when she stepped away from the resident to pick up towels. The report revealed predisposing environmental factors of a wet floor and predisposing physiological factors of confusion, incontinence, gait imbalance and weakness/fainted. A review of the hospital discharge summary dated 06/20/14 indicated Resident #6 was evaluated and treated in the emergency room on 06/19/14 for a laceration above her left eye brow that required the laceration to be repaired with surgical glue. An interview was not able to be conducted with Nurse Aide #2 (NA) but a hand written statement dated 06/19/14 revealed she helped NA #1	F 323	the shower and maintaining a close visual observation during their bathing time to reduce any opportunity of falls from the shower chair. 3. An in-service has been conducted for aides to educate them on the resident□s transfer needs and the requirement of close supervision on all bathing activities in the shower rooms. This was completed on 8/7/2014. 4. The DON or designee will perform audits on at least 3 residents weekly to ensure compliance of the resident□s transfer determination and of the supervision requirement while showering. This audit will continue for 30days and then will be done at least 1x weekly for a total of 90 days, at which time the QA committee will review the audits and determine the need for further monitoring. The Director of Nursing is responsible for compliance	

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F 323	Continued From page 2	F 323		

transfer Resident #6 arm and arm from the wheelchair to the shower chair and helped her shower the resident. The statement indicated NA #2 then showered another resident and took them back to their room with the intention of returning to help NA #1 transfer Resident #6 back to her wheelchair.

Observations of Resident #6 on 07/16/14 at 11:53 AM revealed her to have a light blue bruise above her left eyebrow and light purple bruises to her left arm.

During an interview on 07/16/14 at 4:33 PM Nurse #1 stated NA #3 came to get him to assess Resident #6 who had fallen in the shower room. Nurse #1 stated Resident #6 was lying on her left side when he went into the shower room with skin tears on her left arm and a laceration along her left orbital bone. Nurse #1 stated NA #1 told him she had left Resident #6 in the shower chair to pick up towels and she observed her falling before she could get back to her.

During an interview on 07/16/17 at 4:45 PM with NA #3 stated NA #1 requested his help in the shower due to Resident #6 falling out of her shower chair. NA #3 stated when he went in the shower room he observed Resident #6 lying in the floor on her left side and he immediately went to get the nurse.

During an interview on 07/17/14 at 11:19 AM NA #1 stated she had taken Resident #6 to the shower room and was assisted by NA #2 to arm and arm transfer her to the shower chair. NA #1 stated she knew Resident #6 was to be transferred with a lift but the lift agitated the resident so she didn't use it. NA #1 stated she showered Resident #6 and was waiting on NA #2 to return to the shower room to help her transfer the resident back to her wheelchair and she stepped about an arm's length away from the

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F 323	Continued From page 3 resident to pick up some towels and saw her fall before she could get to her. NA #1 stated she shouldn't have left Resident #6's side while she was sitting in the shower chair. An interview with the Director of Nursing (DON) on 07/17/14 at 7:24 AM revealed she received a phone call on 06/19/14 from Nurse #1 that Resident #6 had fallen out of the shower chair and was being sent to the emergency room for evaluation. The DON stated NA #1 reported she was alone in the shower room with Resident #6 waiting on NA #2 to return and help her transfer the resident back to her wheelchair and she left Resident #6's side to pick up some towels and saw Resident #6 fall and could not reach her in time to prevent her fall. The DON stated it was not acceptable to leave a resident unattended while sitting in a shower chair and Resident #6 was a total lift for all transfers and should not have been manually transferred which could have resulted in another accident.	F 323		