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
	345264	A. BUILDING ______ B. WING ______	C 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

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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 staff interviews and record review the facility failed to provide care without the resident falling out of bed on 2 occasions. The resident sustained a subdural hematoma with the first fall, the care plan was updated for 2 staff to provide care but there was another fall from the bed 10 days later when care was being provided by one nurse aide for 1 of 3 sampled residents that fell (Resident #3). The findings included: Resident #3 was admitted to the facility on 07/01/13 with diagnoses that included Alzheimer's disease, dementia without behaviors, osteoporosis, urinary incontinence, depression and others. A quarterly Minimum Data Set (MDS) dated 09/03/14 specified the resident had severly impaired cognitive skills, did not resist care but required extensive assistance of 2 persons with bed mobility was transferred with a mechanical lift and was always incontinent of bowel and bladder. The MDS also specified the resident had not fallen. Resident #3 had a care plan updated 09/03/14	F 323	Following the fall on 10/20/14, resident #3s care plan was revised to include a defined perimeter mattress, fall mats on both sides of the bed, a body pillow while in bed, and 2 staff members to be present for all care while in bed for safetyall of these interventions remain in place as of 10/28/14. A second investigation related to potential neglect by NA #2 in the incident involving resident #3 was initiated by the Administrator on 10/28/14 @ 3:30pm due to new details brought to the attention of management following the DHSR investigation in terms of appropriate reporting of details surrounding the incident by the nursing assistant initially involved and contradicting information initially reported by NA#2 when the fall occurred--the nursing assistant was placed on suspension per abuse/neglect policy immediately. The investigation was completed on 11/3/14 with findings substantiated for neglect which resulted in the termination of employment of the	11/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/17/2014

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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that specified the resident requried assistance with activities of daily living (ADL). On 09/03/14 the nurse aides' computerized care plan assignment was also updated but did not specify the number of nurse aides required to provide care for Resident #3.

Review of Resident #3's medical record revealed a nurse's entry dated 10/10/14 at 2:49 AM that read in part, nurse aide (NA) #1 called for help. Resident #3 was in the floor bleeding from her right eyebrow. Resident #3 was unresponsive but regained consciousness that was altered. Resident #3's left pupil was fixed and right pupil was sluggish to react to light. Resident #3 was sent to the Emerengcy Department for evaluation and diagnosed with a traumatic brain injury and traumatic subdural hematoma.

Further review of Resident #3's medical record revealed a document titled "History and Physical Examination Report" dated 10/10/14 that specified Resident #3 sustained a 3.2 centimeter laceration to the right face just lateral to the right eye as well as evidence of an acute subdural hematoma. Resident #3 was admitted to the surgical intensive care unit for hourly neurological checks. On 10/11/14 Resident #3 returned to the facility at her usual baseline.

The facility provided an "Incident Report" dated 10/11/14 that specified nurse aide (NA) #1 was providing incontinence care on 10/10/14, when she rolled the resident over that resulted in the resident rolling out of the bed, striking her head on the nightstand.

Resident #3's care plan was updated on 10/14/14 and a new intervention was added that specified

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nursing assistant involved due to her failure to report all details regarding the incident during the initial investigation. All required forms were submitted to the NC Personnel Registry as required.

Nursing staff were in-serviced by the Administrator on 10/30/14 on concerns related to the fall of resident #3 in terms of staff failure to follow the care plan as written, the expectation for staff knowledge of written care plans for each resident, using the kiosks/electronic medical record for the review of each care plan routinely, properly reporting incidents upon occurrence in terms of witnesses and specific details immediately following the incident/accident, and the appropriate way to turn/reposition a resident in bed when working alone (turning resident towards self for safety and getting assistance if needed even if not care planned to require 2 staff members based on personal judgment).

On 11/7/14, The DON and ADON/SDC completed an audit of all current safety devices ordered and in place for all residents to ensure the accuracy of the current care plan. From these findings, the DON and ADON/SDC completed a second audit on 11/7/14 for all residents to:

(a) ensure all safety devices currently ordered are in place/in use

(b) ensure all safety devices and care measures ordered and used by the CNA□s for direct care are on the current written care plan

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"2 staff members for care when in bed."

A nurse's entry dated 10/20/14 at 10:00 AM read in part, nurse was called to Resident #3's room and found Resident #3 laying face on the floor with a 3 centimeter skin tear to bridge of her nose, a 5 ½ inch long laceration to her forehead and a 4 centimeter by 1 ½ centimeter laceration to her left eyebrow. Resident #3 was sent to the Emergency Department for evaluation.

A document titled "History and Physical Examination Report" dated 10/20/14 specified Resident #3 was treated in the Emergency Department for a subdural hematoma and left and right cerebral contusion.

The hospital "Discharge/Transfer Summary" dated 10/21/14 specified Resident #3 was admitted for observation and a CT (computerized tomography) scan revealed resolution of the left subdural hematoma. Neurologically, Resident #3 had not changed and she was released back to the facility.

The facility provided an "Incident Report" dated 10/21/14 that specified on 10/20/14 NA #2 was in the room with Resident #3 and rolled the resident over in bed which resulted in Resident #3 rolling out of bed.

On 10/28/14 at 10:00 AM NA #2 was interviewed and reported that she was trained to reference the facility's computerized care plan assignment system for instructions on residents' individual needs such as bed mobility and transfer status. She explained that she had cared for Resident #3 in the past and on 10/20/14 she provided care as usual. NA #2 stated that she was in the room

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(c) ensure all written care plans match the Smart Charting on the kiosks that are seen/used by the CNA□s for the immediate provision of care

A new form was developed (Questions After a Fall) to be completed by the nurse on duty with an Incident/Accident report following any fall. This form will ensure that more detailed information surrounding the fall is obtained immediately including all witness statements. The Incident/Accident Reporting policy/procedure was revised to include this new form, which must be filled out completely--failure to complete details on the incident/accident report or on the new form will result in disciplinary action up to and including termination.

A new form was created (Get To Know Me) to note basic information for all staff, most specifically CNA□s, regarding individual resident preferences and care/safety measures that are required in order to provide appropriate care in a timely manner. Although CNA□s will continue to have direct access electronically to the care plan, this form includes details such as the use of a mechanical lift, transfer/assistance needs including requirements for 2 staff member assistance, diet/thickened liquids, fluid restrictions, and safety/assistive devices that will more easily indicate changes and revisions to the care plan. The MDS Coordinator or Nursing Supervisor will complete this form electronically within 24 hours of admission as part of the clinical

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with Resident #3 preparing the resident for a transfer with the mechanical total lift. NA #2 explained that this involved placing a lift pad underneath Resident #3. She added that she was alone at Resident #3's bedside when she rolled the resident away from her body to tuck the lift pad underneath Resident #3's backside. In doing so, Resident #3's legs fell off the bed resulting in Resident #3 rolling off the bed and striking her head. NA #2 stated she was unable to stop the resident from rolling off the bed. NA #2 added that NA #3 was in the room providing assistance to Resident #3's roommate. NA #2 stated that she was unaware changes had been made to Resident #3's computerized care plan following her 10/10/14 fall to have 2 staff when providing care in bed. NA #2 stated she could not recall if she had reviewed the computerized care plan assignment for Resident #3 on 10/20/14.

On 10/28/14 at 12:00 PM NA #1 was interviewed and reported that she was providing incontinence care as usual on 10/10/14 at 1:30 AM for Resident #3. She stated she was alone in the room and Resident #3 was in bed, she rolled the Resident #3 away from her body. NA #1 explained that while Resident #3 was on her side, the resident flenched causing the resident to roll off the bed. NA #1 stated that she was unaware of how much assistance Resident #3 required because she cared for the resident at night while she slept. NA #1 stated she assumed it was okay to provide Resident #3 incontinence care alone.

On 10/28/14 at 11:00 AM the MDS Coordinator was interviewed and reported that she was responsible for updating residents' care plans. She explained that when care plans were updated in the computer system the changes

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record. Upon completion, it will be printed and placed in a specified binder on the nursing unit in alphabetical order and will be accessible to staff at all times. As the information on the form changes (addition, revision, or deletion), the MDS Coordinator will immediately note the change on the form in ink including initials and date indicating the change. This form will remain in place with all changes in ink until the next care plan review, at which point a new form will be completed electronically and the process will start over. When changes are made to the form, the MDS Coordinator will immediately report this verbally to the nurse and will also note this change on both the Nurse and CNA 24 hour report forms□from here, it is the responsibility of the nurses and CNA□s to pass the information regarding the change to the next shifts over the 24 hour period. The Resident Assessment & Care Plan policy/procedure was revised to include the use of this new form and the steps that will ensure staff are aware of care plan changes related specifically to safety and care.

An in-service on the Questions After a Fall and the Get To Know Me forms as well as the revisions made to both the Incident/Accident and Resident Assessment & Care Plan policies will be conducted by the ADON/SDC and the Administrator on 11/20/14 and all changes will be implemented immediately following the in-service. Any staff who could not be present for this initial in-service will not be

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F 323	Continued From page 4 were reflected on the nurse aide's computerized care plan assignments. The MDS Coordinator stated that it was the responsibility of the nurse aide to review each resident's computerized care plan assignment for changes. The MDS Coordinator reported that she expected nurse aides to follow the MDS coding when providing care and in the case of Resident #3, she required 2 person assistance with bed mobility. The MDS Coordinator reported that on 10/14/14 changes were made to Resident #3's care plan that specified 2 staff members were to provide care at all times due to the resident's fall on 10/10/14 and due to her debilitated state. The MDS Coordinator reported that it was not her practice to report to nurses or nurse aides when changes had been made to residents' care plans because they were expected to review them daily before starting their assignments. On 10/28/14 at 1:15 PM the Director of Nursing (DON) was interviewed about Resident #3's falls. He stated that it was determined after the fall on 10/10/14 2 nurse aides were to be in the room to provide care for Resident #3. He also reported that nurse aides were to roll residents toward their bodies and not away. The DON stated he was unaware that NA #1 had rolled Resident #3 in the wrong direction on 10/10/14. He also reported that he conducted an investgation into Resident #3's fall on 10/20/14. He explained that in his investigation he concluded that NA #2 did not follow Resident #3's care plan for 2 staff to provide care when in bed. He added that NA #2 stated she was unaware of the change with Resident #3's care plan which resulted in the error. He stated that NA #2 should not have rolled Resident #3 away from her while in bed without another staff member to assist.	F 323	allowed to provide hand-on care until he/she completes this in-service to be completed no later than 11/25/14. The Risk Manager will audit all Incident Reports including the attached Questions After a Fall form for completion. The Risk Manager will address any concerns related to missing information and/or details surrounding the completion of the report and all forms she will follow the revised Incident/Accident Reporting policy in terms of having any missing information completed by the employee within 24 hours of the review. This audit will be indefinite as part of the revised Incident/Accident policy and procedure and will begin on 11/21/14. The Nursing Supervisor on each shift will review (1) random care plan on each unit each shift to verify that all safety and care measures listed on the care plan are: "current on the Get To Know Me form "the assigned nursing assistant is aware of these care planning measures and able to discuss/explain upon being questioned "all information listed on the form is in fact being followed/visually in place These reviews will be done each shift (1st, 2nd, 3rd) Monday through Friday as well as on 1st shift on Saturday and Sunday daily x 4 weeks, weekly x 4 weeks, and then monthly x 4 months. Issues noted in any step will be identified, documented, and corrected immediately. Staff involved in any area requiring	

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F 323	Continued From page 5	F 323	correction will be re-educated and/or issued disciplinary action up to and including termination as necessary depending upon the severity of the issue. These audits will begin on 1st shift on 11/21/14. In the event of the absence of a shift supervisor, the Risk Manager will complete the required audit as necessary. The ADON/SDC will review all Nurse and CNA 24 hour reports weekly X 6 months beginning on 11/24/14 to compare the reports to all Get To Know Me forms to ensure written communication has been followed per policy. Issues noted in any step will be identified, documented, and corrected immediately through re-education and/or issued disciplinary action up to and including termination as necessary depending upon the severity of the issue. The DON will monitor the results of all audits from each Nursing Supervisor and the ADON for any concerns as well as any concerns reported by the Risk Manager related to the completion of incident/accident reports/forms. The DON will report results, trends, and patterns of these audits to the QA&A Committee monthly x 6 months. The QA&A Committee will determine if any further interventions or systemic changes are needed to assure continued compliance with F323.	