STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 08/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an initial assessment on a newly admitted resident prior to leaving the resident unattended on a bed pan which resulted in a fall with injury (Resident #1) for 1 of 3 residents reviewed for accidents. Findings included: Review of a hospital discharge summary dated	F 323	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed, in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of	8/23/17

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

Electronically Signed | 08/16/2017

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F 323	Continued From page 1 7/24/17 for Resident #1 read in part, "daily activity: as tolerated, use fall precautions." Resident #1 was admitted on 07/25/17 with diagnoses that included hepatic failure (loss of liver function), rheumatoid arthritis, diabetes, muscle weakness, and lack of coordination. Review of the facility's Nursing Admission Assessment/Screening document dated 7/25/17 for Resident #1 revealed in part: Admission details: unable to bear weight and refused to help with any transfer. Orientation and Cognition: alert and oriented to self; confused with short and long term memory deficit. Motor Control: unsteady gait, poor balance, history of falling/recent fall. Skin: normal; no redness or open areas. Activities of Daily Living (ADL): total assist of 2 to perform ADL. Other Observations/Concerns: "fall risks, continues to attempt to climb out of bed." Review of the incident report dated 07/25/17 revealed Resident #1 fell out of bed by crossing her right leg over the side of the bed and rolled onto the floor. Resident #1 was documented as stating, "I just fell." Staff actions at the time of the incident indicated Resident #1 was assessed and noted to "have a small pump knot in the middle of her forehead." The nurse assessment indicated Resident #1 had range of motion to all major joints and neuro checks were started. Nurse #1's comment read "Resident #1 fell within one hour of admission. Staff was unable to complete assessment before she fell to put safety measures into place." There was no evidence	F 323	correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the date indicated. F323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □Resident #1 placed on bed pan, CNA left the room and the patient rolled off the bed. Fall interventions put in place after fall were 1) pad alarm, 2) Bolster mattress, 3) floor mats next to bed, 4) bed in lowest position, 5) pad call light. Neuro checks implemented. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ The Director of Nursing/Unit Manager or designee will educate all licensed nurses and CNAs on staff as well as new nurses and CNA□s on hire, on maintaining environment free of accident hazards, adequate supervision to prevent accidents on new admissions. This will include that within the first 24 hours of admission a patient will be under direct supervision for toileting by a CNA if they require the use of a bed pan for toileting in that timeframe. This was completed on August 23, 2017. Any staff member not having the education completed, will not be allowed to work until they have completed the	

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F 323	Continued From page 2 indicating Resident #1 had requested privacy while using the bed pan. Review of the post fall nursing note dated 7/25/17 revealed Resident #1 fell at 5:35 PM when attempting to get out of bed. Interventions initiated in response to Resident #1's fall included for staff to monitor for changes in behavior, promote hydration, therapy referral for evaluation, relocation to a room closer to the nurses' station, restorative toileting program, and provide education for Resident #1 to call for assistance. Actions following the fall included: pad alarm, bolster (support) mattress, floor mats next to the bed, bed in lowest position, and pad call light. Review of the situation background assessment recommendation nursing note dated 07/26/17 read in part, change of condition due to fall on 07/25/17 during the afternoon. On call Nurse Practitioner (NP) notified at 9:00 PM. Orders received to place ice and start neuro checks. The Computed Tomography (CT) Scan dated 07/28/17 for Resident #1 was reviewed. The results indicated the CT scan performed on 07/28/17 was compared to a CT scan performed on 07/12/17 which revealed "new, mildly impacted bilateral nasal bone fractures; no significant overlying soft tissue swelling, raising consideration for a subacute chronicity of injury." Resident #1 had been discharged to the hospital on 07/28/17 and was not able to be interviewed. Review of the facility's incident follow-up dated 07/31/17 revealed Resident was admitted to the facility at 5:00 PM, was oriented to her room and educated on call bell use at 5:20 PM. Further	F 323	required education. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- CNA and Nurse will complete a toileting monitor for the first twenty-four hours of admission on any patient requesting to be toileted and requiring the use of a bed pan. The form will be signed, by the CNA toileting the resident and by the Charge Nurse responsible for the care of the patient and oversight of the CNA. The Director of Nursing will collect these signature sheets. Any observations that indicate a no response, the CNA will be re-educated on the requirement, if the incident re-occurs, then disciplinary action will be taken. The observation tools will be collected daily for all new admissions Monday-Friday. Mondays collection will include admissions from Friday, Saturday and Sunday for 8 weeks, weekly x 4 weeks, bimonthly x 2 months, and monthly x 1. How facility will monitor corrective action(s) to ensure deficient practice will not Re-occur- The results observation sheets will be reviewed weekly by the Director of Nursing in the weekly Quality Assurance Risk Meetings X 6 months. The Administrator will ensure the results are discussed during the Quarterly Quality Assurance Meetings X2 for further problem resolution and revision as	

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F 323	Continued From page 3	F 323		

review revealed Resident #1 asked to use the bathroom, was placed in "safe position" by staff, instructed to use the call bell when finished, and left unattended for privacy. It was noted that approximately 5 minutes later Resident #1 was found on the floor lying on her belly when staff returned to her room and was assessed for injuries which revealed a "small pump knot" on her forehead with no other injuries noted. There was no evidence indicating Resident #1 had requested privacy while using the bed pan.

During a telephone interview on 08/03/17 at 9:34 AM Resident #1's Family Member (FM) indicated they had not been present at the facility when she had arrived for admission or when she fell. The FM confirmed they had been notified by the nurse of Resident #1's fall and when they had arrived at the facility, she had a "pump knot" in the middle of her forehead and her nose was swollen. The FM added Resident #1 was a fall risk and should not have been left unattended. The FM stated they felt Resident #1 had fallen because staff had not assessed her and were not aware of what assistance she had needed.

Attempts to speak to the Emergency Department Physician were made on 08/03/17 and 08/04/17 but he was unavailable for interview.

During a telephone interview on 08/04/17 at 10:24 AM Nurse #1 confirmed she had worked on 07/25/17 when Resident #1 had been admitted to the facility and had received in report from the hospital that she needed assistance with all ADL. Nurse #1 stated the hospital had not informed her Resident #1 was a fall risk. She explained when they were informed a resident was considered a fall risk, staff made sure fall precautions, such as

needed.

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F 323	Continued From page 4	F 323		

fall mats, were in place prior to the resident's arrival. Nurse #1 recalled Resident #1 had only been at the facility for less than an hour when she had requested to use the bathroom and the NA had assisted her onto the bed pan. She added Resident #1 had been left alone for privacy when she had fallen out of the bed. Nurse #1 stated she had immediately assessed Resident #1 for injuries which revealed a "small bump to her forehead and slight bleeding from her mouth where she had bit the tip of her tongue." She added there had been no bruising, swelling or indication of fracture noticed. Nurse #1 indicated Resident #1 had complained of no pain, her vitals were within normal limits and had full range of motion. Nurse #1 confirmed the on-call NP had been notified and instructed her to monitor Resident #1 for changes, initiate neuro checks and place ice packs to her forehead. Nurse #1 acknowledged she had not had time to review the hospital discharge summary or complete a full assessment on Resident #1 before she had requested to use the bathroom but she had been instructed on how to use the call bell for assistance. Nurse #1 stated if "we had known she was a fall risk she would have never been left unattended."

During an interview on 08/04/17 at 11:20 AM the Director of Nursing (DON) indicated there were no standard fall interventions utilized for newly admitted residents as a precaution measure in the event of a fall. She explained when residents first arrived to the facility, the nursing staff immediately oriented them to their room and provided them with instruction on how to use the call light for assistance until a full assessment could be completed. The DON stated she felt it was appropriate for staff to leave Resident #1

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F 323	Continued From page 5	F 323		

unattended on the bed pan if she had answered questions appropriately and wanted privacy.

During an interview on 08/04/17 at 11:33 AM the Unit Coordinator (UC) confirmed she had been working on 07/25/17 when Resident #1 was admitted to the facility. The UC explained that prior to accepting Resident #1 to the facility, she had reviewed the initial paperwork from the hospital in order to determine if the facility was able to meet her needs. She added the hospital had not mentioned Resident #1 was a fall risk and that all hospital discharge summaries included the statement "use fall precautions." The UC indicated Nurse #1 had informed her that Resident #1 had rolled out of bed while using the bed pan and when she had arrived to assess the situation, staff had already placed Resident #1 back in bed. She added Resident #1 had sustained a "small pump knot on her forehead" but displayed no other facial or head trauma such as bruising or swelling. The UC stated Resident #1 complained of no pain after her fall and staff had continued to monitor Resident #1 for changes per facility protocol.

During a telephone interview on 08/04/17 at 1:35 PM Nurse Aide (NA) #1 confirmed she had worked on 07/25/17 when Resident #1 was admitted to the facility and had assisted her onto the bed pan. NA #1 stated she had been unaware the facility was receiving a new admission and when she noticed her being brought to the room, she had went in to introduce herself and see if she needed anything. NA #1 recalled Resident #1 had stated she needed to use the bathroom and informed the NA she was unable to walk to the bathroom. NA #1 stated she had asked her if she would like to use a bed

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F 323	Continued From page 6	F 323		

pan and Resident #1 had replied yes. NA #1 explained that once Resident #1 was situated on the bed pan in the middle of the bed, she handed Resident #1 the call light to use when she was finished, and shut the door to her room to give her privacy. NA #1 added Resident #1 had only been left unattended approximately 5 to 6 minutes when she had fallen out of bed. She indicated Nurse #1 had immediately come to the room to assess for injuries and Resident #1 had informed them "I'm not supposed to be by myself. I am a fall risk." NA #1 confirmed she had not been informed by the nurse or Resident #1 of any fall risk prior to leaving the resident unattended. NA #1 explained unless they were a fall risk, she would normally leave an alert and oriented resident unattended on a bed pan to give them privacy. NA #1 added she had felt comfortable leaving Resident #1 unattended since she had been able to answer questions appropriately and voiced understanding of how to use the call bell.

During a follow-up interview on 08/04/17 at 1:50 PM the DON stated she would expect for staff to use "standard practice" (usual thing done in a particular situation) when assisting residents to the bathroom or using a bed pan. The DON indicated she had been informed by staff that the hospital had not reported Resident #1 was a fall risk and explained the hospital included the generic statement to "use fall precautions" on every discharge summary. She added the discharge summary was not always received prior to the resident arriving at the facility. The DON stated she had been informed Resident #1 had not been at the facility long when she requested to use the bathroom and the nurse had not had time to complete a full assessment in order to inform the NA of any needs. The DON

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F 323	Continued From page 7 stated since Resident #1 had been alert and oriented she felt staff had been appropriate to leave her unattended when using the bed pan for privacy. During an interview on 08/04/17 at 2:09 PM the Administrator stated she couldn't expect for nurses to go by what was listed on the hospital discharge summary. The Administrator explained nursing staff assessed all new residents and reported to the NA what level of care was needed. She added she would expect for staff to use their best judgment when determining if a resident could be left unattended when using a bed pan.	F 323		