STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 03/24/2011

APR 15 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - TREYBURN	2059 TORREDGE ROAD DURHAM, NC 27712

(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 a place a fall floor mat on the floor beside the bed and failed to safely position a resident while bathing for 1 of 3 sampled residents (Resident #2) known to be at risk for falls. Findings included: Resident #2 was admitted to the facility on 4/10/08 and readmitted on 2/17/11 with diagnoses that included Alzheimer ' s, Dementia, Diabetes, Failure to Thrive, and Anorexia. The Minimum Data Set (MDS) completed on 2/24/11 indicated the resident required extensive assistance of one with bed mobility, transfer, toilet and hygiene. The resident was totally dependent on staff for one person physical assist with bathing. There was no occurrence of balance during transitions and walking. The resident was indicated as having no impairment to the upper extremities and impaired on both sides of the lower extremities. Additionally, the resident was indicated not steady, only able to stabilize with human assistance for surface to surface transfer (between bed and chair or wheelchair). The resident was indicated with a history of a fall with no injury or pain. The MDS also indicated the	F 323	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.* ***This Plan of Correction is the facility's credible allegation of compliance.*** F 323 First Aid was administered to resident #2 immediately & transported to ER for evaluation and treatment on 3/15/11 for head laceration. Resident was evaluated and treated by facility Orthopedist on 3/18/11 for orders and treatment plan. Bilateral Mats were in place beside low bed. *Resident Care Information Sheet* updated to reflect resident status and care instructions immediately. The bedside table/nightstand was positioned on the right side of the bed against the wall and a safe distance away from the resident. **For those with potential to be affected.** Administrator/ DON/ Unit Coordinator utilized audit tools to conduct a 100% audit of all residents/resident rooms with safety measures (ie. floor mats, low beds, personal alarms, sensor pads) to ensure compliance with their plan of care.	3/18/11 4/1/11

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

Administrator 4/13/11

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 resident cognitive pattern was severely impaired with a score of " 00. " The Care Area Assessment Summary completed on 1/3/11 indicated the resident required approaches to minimize the risk for injury and falls. The care plan indicated on 4/10/08 as a fall risk intervention the floor was to be padded next to the bed. On 4/1/09 the care plan indicated continue with the floor as padded next to the bed. On 5/5/09 the care plan indicated continue with the mats " Mat effective. " On 4/12/10 the care plan indicated changed with annual (not specified what the change included). The care plan revealed on 3/3/11 the staff was in-serviced related to the winged mat. The Resident Care Information Sheet-care guide (undated), located at the nurses ' station indicated special instructions that included " Mats by bed, winged mat, two persons assist with bed mobility, wheel chair and transfers; fall risk, non-weight bearing (status post hip fracture, can get up to wheelchair with two person assist) non-ambulatory, bed/chair alarm. " Record review revealed from 2/10/11-2/17/11 the resident was hospitalized due to a family member called 911. The resident was not sent to the hospital prior to the 911 call by the nursing facility; due to a physician ' s order dated 12/15/10 that indicated the resident was comfort care, per request of the responsible party. Past medical history and diagnoses revealed no evidence of fractures. The facility ' s readmission assessment revealed on 2/17/11 the resident complained of no pain, and there were no signs/symptoms of pain. The admission assessment also indicated an assessed fall risk score of 11, which indicated a high risk for potential falls. The side rail evaluation completed on 2/17/11 revealed the resident was	F 323	Administrator/ DON/ Unit Coordinator completed a 100% audit of all *Resident Care Information Sheets* and *Resident's Plan of Care*. All *Resident Care Information Sheets and Resident's Plan of Care* were updated to reflect the resident's needs. The information included but not limited to safety equipment, transfers, bed mobility, and bathing assistance needs. Nursing Staff was provided one-on-one re-education on utilizing the information on the *Resident Care Information Sheet* at the beginning of shift assignment. Licensed Nurses to update *Resident Care Information Sheet* with order changes or change in *Resident's Plan of Care.* Nursing Staff (C.N.A's and Licensed Nurses) were re-educated on walking nursing rounds between shifts, ensuring all safety measures are in place, and resident's rooms are free of hazards. **Plan will be Monitored by:** DON/Nursing Managers/Administrator, as part of compliance rounds, will observe resident safety measures, i.e.: floor mats, low beds, personal alarms, and sensor pads are in place to ensure resident safety. DON/Nursing Managers/ Administrator will make rounds of resident's environment. Random Audits will be completed weekly for 4 weeks and Bi-weekly for 2 months. Ongoing audits will be determined by results of prior 3 months of auditing. DON will report findings of audits to QA&A Committee Monthly x 3 months for review and recommendations.	4/1/11 4/3/11 4/15/11 4/21/11

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F 323	Continued From page 2 non- ambulatory and non-weight bearing. Therefore, the resident was assessed as needed no side rails. Facility record revealed on 3/3/11 at 7:30 AM the resident rolled out of the bed without injury. The bed was documented in the low position. Further review of the facility records revealed Nurse #1 indicated upon entry into the room the floor mat was not in place on the floor, the bed was in the lowest position and the resident was located on the floor, positioned on the side. Facility documentation indicated the resident was assessed by Nurse #1 and no injuries or pain were noted. The resident was assisted back into the bed by the staff. Facility record revealed on 3/3/11 the staff was in-serviced on all shifts to ensure the bed alarms were attached, beds were positioned in the lowest position and the floor mats were placed bedside the residents ' beds that were identified at risk for falls. Facility record revealed a family member requested an x-ray to be completed while the resident was evaluated at the hospital, for a head laceration that occurred on 3/15/11 while at the nursing facility. The family member observed the resident slightly wincing with movement of the left hip. Results of the hospital x-ray report dated 3/15/11 read, " Two views of the left hip: There is a fracture of the left femoral neck. The possibility of an underlining pathologic etiology could not be completely excluded but the appearance is more suggestive of a subacute fracture with various deformity. " Further review of the hospital record revealed the injury likely occurred 2-3 weeks prior to 3/15/11. On 3/22/11 at 1:10 PM, the resident was positioned in a low bed without side rails. Floor mats were positioned on the floor on both sides of	F 323		

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F 323	Continued From page 3 the bed and the call bell was located in reach. The resident was unable to engage in a conversation and responded to simple questions, as indicated by " Yes, no, or a moan. " There was a laceration scar above the resident ' s right eyebrow. Interview on 3/22/11 at 5:15 PM with NA #4 revealed she bathed, turned/repositioned, and transferred the resident from the bed to the broda chair independently during morning care. When asked where she would look to find out if there was any changes or updates on how to care for the resident, NA #4 stated she would ask the charge nurse. Interview on 3/23/11 at 12:40 PM with Nurse #1 revealed on 3/3/11 at approximately 7:30 AM she entered into the resident ' s room after summoned by NA#1 and observed the resident lying on the floor, positioned on the left side (beside the left side of the bed) facing the door. She indicated there was no floor mat on the floor. Nurse #1 further indicated, the floor mat was positioned up against the wall, and was not located where it should have been, on the floor under the resident. Nurse #1 elaborated, she suspected the nurse aides probably forgot to place the floor mat back in the proper place (on the floor beside the bed) after rounds were completed. Nurse #1 concluded the resident was assessed and complained of no pain and the bed alarm was intact and alarming. Interview on 3/23/11 at 2:10 PM with NA #1 revealed, on 3/3/11 at the start of her shift (1st shift) she heard an alarm sounding on the unit. NA #1 indicated upon getting to the resident door, she observed the resident lying on the floor on the left side of the bed facing the door, but could not recall what side (side of the body) the resident was positioned on. NA #1 further indicated, she	F 323		

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F 323	Continued From page 4 could not remember if the floor mat was positioned on the floor. NA #1 indicated she immediately screamed for Nurse #1. NA #1 elaborated the resident was assessed by Nurse #1. Thereafter, the resident was rolled onto a sheet while lying on the floor by Nurse #1 and lifted from the floor, back into the bed while on the sheet, with two persons at the top (head) and two persons at the bottom (feet). NA #1 stated she did not recall if the resident complained of pain. NA #1 concluded no shift report or walking round was completed with the off-going nurse aide. She indicated she usually consulted with her charge nurse for any needed updates in residents ' condition, as part of her normal routine. Interview on 3/23/11 at 3:35 PM with Nurse #2 revealed approximately 5-6 months ago she recalled the resident attempted to get out of the bed/wheelchair unassisted and the bed/chair alarms would sound. However, she had not noticed any recent attempts to get up unassisted, since her physical condition declined. Interview on 3/23/11 at 3:50 PM with NA #2 (assigned 3rd shift NA morning of fall) indicated she did not recall moving the floor mat from either side of the bed during her shift. She indicated she usually clocked out between 7:00-7:05 AM and did not recall doing a walking round, or shift report with the oncoming nurse aide. Interview with Nurse #3 (Unit Manager) on 3/23/11 at 4:20 PM revealed the floor mats were implemented greater than 5 months ago for falls, to be placed on both sides of the bed. She further indicated the floor mats were still an active part of the care plan and should have been in place on the floor, beside the bed, on the day of the fall. Interview on 3/24/11 at 6:05AM with Nurse #4 (assigned 3rd shift nurse morning of fall) indicated she did not recall moving the floor mat	F 323		

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F 323	Continued From page 5 during her shift. Nurse #4 concluded the mat should have been positioned on the floor on both sides of the bed at all times. Interview on 3/24/11at 6:10 AM with NA #2 revealed she had cared for the resident independently to present and was not notified the resident required two staff assist at all times. NA #2 indicated Nurse #4 informed her on 3/23/11 the resident required two person physical assist. Interview on 3/24/11 at 6:27 AM with Nurse #5 (Nursing supervisor) revealed he informed staff to ensure the residents ' floor mats were in place and any other fall prevention device was intact and functioning (alarms). Interview on 3/24/11 at 11:25 AM with the Director of Nursing (DON) revealed she compared the hospital x-ray report completed on 3/15/11 to the facility ' s x-ray report completed on 3/19/11. The DON further indicated she requested a re-read of the facility ' s x-ray report completed on 3/19/11 by the contracted x-ray company on 3/23/11. She indicated she requested a re-read to rule out any pathological factor that would have contributed to the fracture. Review of the facility ' s re-read x-ray report completed 3/23/11 at 5:32 PM indicated significant findings of two-views of the left hip that showed a subcapital fracture of the left femur, with no other fractures identified. An addendum impression note to the initial facility ' s x-ray report completed on 3/19/11 indicated " Generalized osteopenia of the left hip, left femur, and visualized portion of bony pelvis probably on the basis of osteoporosis. " Interview on 3/24/11 at 7:40 PM with the Staff Development Coordinator (SDC) revealed she expected the staff to know the residents ' care needs at the start of the shift. This involved upon arrival on the unit, checking to ensure floor mats,	F 323		

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F 323	Continued From page 6 bed alarms, call bells and other safety devices were in intact or properly place. Interview on 3/24/11 at 8:15 PM with the Director of Nursing revealed she expected the floor mats to be positioned beside the bed for any resident whose care plan indicated as an intervention/approach. The DON also indicated she expected the nurses/nurse aides to do walking rounds and shift report, upon arrival on the unit. The DON concluded the facility had started an action plan (after survey entry) of re-educating the staff on all shifts. Record review revealed on 3/15/11 at approximately10:30 AM Nurse #1 documented the nurse aide was bathing the resident in bed and rolled the resident onto her side and the resident rolled into the night stand and hit her head, causing a laceration. First aide was administered and the resident was transported to the hospital for sutures. Record review dated 3/15/11 at 10:35 PM revealed the resident returned from the hospital to the nursing facility with sutures to the forehead, with a change in mobility/transfer status to two person ' s physical assist. The hospital report dated 3/15/11 indicated the resident had a soft tissue scalp laceration to the right forehead with no underlining fracture. Facility record revealed on 3/15/11 the staff was in-serviced regarding turning/repositioning, handling fragile residents, and the staff was informed to use two person physical assist, at all times when providing care. The bedside table was removed to prevent any further injuries. On 3/22/11 at 1:10 PM, the bedside table was not positioned next to the bed. The night stand was positioned on the right side of the bed against the wall, one arm length or greater away from the resident ' s bed. Interview on 3/22/11 at 5:15 PM with NA #4	F 323		

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F 323	Continued From page 7 revealed she bathed, turned/repositioned, and transferred the resident from the bed to the broda chair independently, during morning care. Interview on 3/23/11 at 2:40 PM with Nurse #1 (assigned nurse on duty day of laceration) revealed the bed was in a high position when care was provided to the resident. She further indicated when NA #3 pulled the pad under the resident close to her, the resident flopped over and hit her head on the bed-side table. Nurse #1 concluded the resident was assessed and complained of no pain and was transported to the hospital. Interview on 3/23/11 at 3:50 PM with NA #2 revealed she turned/repositioned and provided incontinent care independently on third shift on 3/23/11. NA #2 further indicated she used the pad underneath the resident, to turn the resident to one side and then back to the other side, without help from another nursing staff. Interview on 3/23/11 at 4:20 PM with Nurse #3 (Unit manager) revealed two aides were required at all times when physical care was provided to the resident. Nurse #3 also indicated care was to be provided per the revised resident care guide (located in the nurse aides flow book at the nurses ' station), implemented the same day after the laceration occurred. Interview on 3/24/11at 6:10 AM with NA #2 revealed she had cared for the resident independently since 3/15/11 (date of laceration) to date and was not notified that two persons were required at all times, when care was provided. NA #2 indicated Nurse #4 informed her on 3/23/11 the resident required two person physical assist. Interview on 3/24/11 at 6:27 AM with Nurse #5 (Nursing Supervisor) revealed to date, one person turned/repositioned, and provided incontinent care for the resident. Nurse #5	F 323		

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F 323	Continued From page 8 elaborated this was how the staff cared for the resident on 3rd shift and he had not been informed to do otherwise. He also indicated he did not recall attending an in-service related to two person physical assist. Nurse #5 indicated he had no idea the resident care guide posted at the nurses ' station had been revised. He concluded the revised resident care guide did not indicate a date, wherein, changes were implemented. Interview on 3/24/11 at 7:10 AM with NA #3 revealed on 3/15/11 the resident appeared weaker than usual. She further indicated after she finished providing genital care and pericare, she was positioned on the side of the bed with her back facing the door. NA #3 then pulled the draw sheet underneath the resident toward her and the resident body went forward to the edge (side) of the bed and her forehead head hit the edge of the night stand, located at the head of the bed. NA #3 further indicated the bed was positioned very close to the night stand, at the time she turned the resident. She also indicated the bed was positioned (elevated) at a comfortable height for her to turn, reposition and bathe the resident. NA #3 concluded she informed Nurse #3 (Unit Manager) the resident may require two people assist, on the day of the incident (after occurrence). Interview on 3/24/11 at 7:40 PM with the SDC revealed she expected the staff to assess the environment (resident room) to ensure the resident was safe and prevent injury. The SDC also indicated she expected the staff, after he or she assessed the environment, to get assistance from another nursing staff, if there was any indicative change in the resident ' s condition or get guidance from the charge nurse. Interview on 3/24/11 at 8:15 PM with the DON revealed she expected the staff to assess the	F 323		

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F 323	Continued From page 9 environment (resident room) to ensure, any accidental causing agent was removed before care was provided. The DON further indicated she expected the staff to use pillows during turning and repositioning as a protector between the resident and anything that could contribute to an injury. The DON concluded the facility had started an action plan (after the survey entry) of re-educating the staff on all shifts.	F 323		