STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	C 05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LEAF HEALTH CARE	2640 DAVIE AVENUE STATESVILLE, NC 28625

(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 000	INITIAL COMMENTS The original complaint survey was conducted from May 10-11, 2011. Based upon management review, the survey dates were extended. The survey team reentered the facility on May 25, 2011 and notified the administrator of the IJ at F309. The exit date was extended to May 27, 2011 at which time the jeopardy was removed and F309 was left out of compliance at a lower scope and severity.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	F 225 1. Corrective action has been accomplished for the alleged deficient practice by submitting a corrected 24- hour initial report on 5/11/11. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Administrator has completed an audit of reportable files within the last 3 months to assure timeliness of reporting has occurred. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Administrator or Director of Nursing completed inservice "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 provisions of federal and state law."	6/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer K. Simon — TITLE: Administrator — (X6) DATE: 6/22/11

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 225	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, Health Care Personnel Registry interview and record review the facility staff failed to submit the 24-Hour Initial Report within twenty-four hours to the Health Care Personnel Registry in one (1) of four (4) sampled investigations for injury of unknown origin. (Resident # 1) The findings are: A review of the Nurse Aide and Healthcare Personnel Reporting Guideline 24-hour report dated 04/30/11 and completed by the Director of Nursing (DON) revealed allegations were identified as resident neglect and injury of unknown source. The report stated Resident #1 was sent to emergency room due to garbled speech, facial droop, low oxygen saturation and was admitted with stroke, aspiration pneumonia and a crush fracture to the left leg. The documentation stated "the injury to her leg may be related to a transfer performed by two employees who had to lower Resident #1 to the floor after attempting transfer using sit to stand lift	F 225	education as of 6/16/11 for facility staff regarding abuse neglect reporting practices, specifically, the requirements related to timely reporting to state or local agencies. The Administrator will review 24-hour initial reports and 5 working day reports to state agencies, as they occur, to ensure timely reporting has been accomplished. A fax confirmation sheet will be retained by the Administrator as part of the report file. 4. The Administrator will review the results of reportable incidents and report to the QA&A Committee weekly for four weeks and then monthly thereafter. The QA&A Committee consists of Administrator, Medical Director, Director of Nursing, Resident Care Management Director(RCMD), Unit Coordinator, Social Worker, Food Service Director, Activities Director, Therapy Program Manager, MDS Coordinator, Medical Records Director and other Interdisciplinary Team members. The QA&A committee "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 provisions of federal and state law."	6/22/11

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F 225	Continued From page 2 unsuccessfully. The resident's family members told us about the fracture today, we had not received that information from the hospital at all. I am opening the investigation now, family states that ER doc told them the fracture was between 1 - 4 days old." A review of the Nurse Aide and Healthcare Personnel Reporting Guideline 24-Hour "corrected report" dated 05/11/11 by the DON revealed revisions in part that stated NA's had to lower Resident #1 to the floor after attempting transfer using sit-to-stand lift unsuccessfully. An interview on 05/10/11 at 10:21 a.m. with the DON revealed she first heard about Resident #1's fracture when the family came to the facility on 04/29/11 to pick up Resident #1's clothing. The DON explained she came back to the facility on 04/30/11 to get written statements from both NA's involved in the incident and placed them on suspension pending an investigation. A phone interview on 05/24/11 at 9:15 a.m. with the North Carolina Health Care Personnel Registry Section revealed they did not receive a 24-Hour Initial Report from the facility. A phone interview on 05/26/11 at 3:27 p.m. with the North Carolina Health Care Personnel Registry Section revealed they received a corrected 24-Hour Initial Report which had been faxed to the facility on 05/11/11.	F 225	will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance.	6/22/11
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226	"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 provisions of federal and state law."	

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F 226	Continued From page 3 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, Health Care Personnel Registry interview and record review the facility staff failed to submit the 24-Hour Initial Report to the Health Care Personnel Registry in one (1) of four (4) sampled investigations for injury of unknown origin. (Resident # 1) The findings are: A review of facility policy titled "Abuse & Neglect Prohibition" and dated February 2010 stated under "Investigation" the facility will report such allegations to the state, as per state regulation. A review of the Nurse Aide and Healthcare Personnel Reporting Guideline 24-hour report dated 04/30/11 and completed by the Director of Nursing (DON) revealed allegations were identified as resident neglect and injury of unknown source. The report stated Resident #1 was sent to emergency room due to garbled speech, facial droop, low oxygen saturation and was admitted with stroke, aspiration pneumonia and a crush fracture to the left leg. The documentation stated "the injury to her leg may be related to a transfer performed by two employees who had to lower Resident #1 to the floor after attempting transfer using sit to stand lift unsuccessfully. The resident's family members told us about the fracture today, we had not received that information from the hospital at all. I am opening the investigation now, family states	F 226	F226 1. Corrective action has been accomplished for the alleged deficient practice by submitting a correct 24- hour initial report on 5/11/11. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Administrator has completed an audit of reportable files within the last 3 months to assure timeliness of reporting has occurred. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Administrator or Director of Nursing completed inservice education as of 6/16/2011 for facility staff regarding abuse neglect reporting practices, specifically, the requirements related to timely reporting to state or local agencies. The Administrator will review 24-hour initial reports and 5 working day reports to state agencies, as they occur, to ensure timely reporting has been accomplished. A fax confirmation sheet will be "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 provisions of federal and state law."	6/22/11

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F 226	Continued From page 4 that ER doc told them the fracture was between 1 - 4 days old." A review of the Nurse Aide and Healthcare Personnel Reporting Guideline 24-Hour "corrected report" dated 05/11/11 by the DON revealed revisions in part that stated NA's had to lower Resident #1 to the floor after attempting transfer using sit-to-stand lift unsuccessfully. An interview on 05/10/11 at 10:21 a.m. with the DON revealed she first heard about Resident #1's fracture when the family came to the facility on 04/29/11 to pick up Resident #1's clothing. The DON explained she came back to the facility on 04/30/11 to get written statements from both NA's involved in the incident and placed them on suspension pending an investigation. A phone interview on 05/24/11 at 9:15 a.m. with the North Carolina Health Care Personnel Registry Section revealed they did not receive a 24-Hour Initial Report from the facility. A phone interview on 05/26/11 at 3:27 p.m. with the North Carolina Health Care Personnel Registry Section revealed they received a corrected 24-Hour Initial Report which had been faxed from the facility on 05/11/11.	F 226	retained by the Administrator as part of the report file. 4. The Administrator will review the results of reportable incidents and report to the QA&A Committee weekly for four weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance.	6/22/11
F 242 SS=G	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242	F242 1. Corrective action could not be accomplished for Resident #1. "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 provisions of federal and state law."	6/22/11

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F 242	Continued From page 5 are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to honor one (1) of one (1) sampled resident's preference not to take a shower and wear her choice of clothing (Resident #1). The findings are: Review of Resident #1's record revealed an admission date of 3/31/11 with diagnoses including Chronic Obstructive Pulmonary Disease and Osteoarthritis. Review of the admission Minimum Data Set (MDS) dated 4/7/11 revealed assessment of short term and long term memory problems and moderately impaired decision making abilities. The MDS assessment coded Resident #1 could make herself understood and understood others with no behavior problems. The MDS listed the resident required limited assistance with personal hygiene and dressing; extensive assistance was required with transfers. The MDS listed there was no bath given during the assessment period. Review of Resident #1's nursing care plan dated 4/12/11 revealed no concerns regarding crying episodes or resistance to care. Review of nursing notes dated 4/27/11 at 6:00 PM revealed Licensed Nurse (LN) #1 documented the "CNAs (Certified Nursing Assistants) present state pt. was told she would get a shower to which she refused and became upset." LN #1 documented "She remained upset for well over an hour and refused to eat dinner."	F 242	The resident expired on 5/2/11. NA#2 and NA#3 have been re-educated and counseled regarding residents right to make choices, regarding showers and choice of clothing. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the RCMD and/or MDS Coordinator have completed an audit of those residents who are dependent for bathing and dressing based on the most recent MDS assessment. An audit of interviewable residents has been also been conducted by Social Services Director and/or Unit Coordinator regarding residents' preference for bathing and choice of clothing. The Administrator has reviewed Resident Council minutes to identify concerns related to honoring preferences and choices. The Administrator has also reviewed concerns for the past ninety days to identify issues related to preferences and choices. "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 provisions of federal and state law."	6/22/11

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F 242	Continued From page 6 Review of a facsimile dated 4/27/11 sent at 6:20 PM revealed LN #1 requested an anti-anxiety medication because Resident #1 "became very upset with staff who tried to give her a shower." Review of Resident #1's hospital admission history and physical dated 4/27/11 listed diagnoses including acute fracture of the left tibia plateau. Review of the facility's five day investigation which included a statement by NA #2 dated 4/30/11 at 2:07 PM revealed a description of lowering Resident #1 to the floor and transfer back to bed. The statement continued: The resident refused to go to the shower prior to the incident. Staff decided that since the resident was so upset about going to the shower, they gave her a bed bath. Review of the facility's five day investigation which included a statement by LN #1 dated 5/3/11 revealed the following: "Around 4:15 PM I was at the end of the hall in front of (room number) and heard (Resident #1) crying. I medicated 2 other residents and still heard her crying. I then entered her room and asked (NA #2) what was wrong with (Resident #1) and she stated she was upset because she didn't want to take a shower and they had lowered her to the floor because she wouldn't stand." Interview with LN #1 on 5/10/11 at 3:45 PM revealed she heard Resident #1 crying on 4/27/11 during the afternoon medication pass. Upon entry into the room, LN #1 reported she observed Resident #1 crying while seated in a mechanical	F 242	3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Director of Nursing, RMCD, Unit Coordinator, and MDS Coordinator completed inservice education as of 6/16/2011 regarding the residents right to make choices specifically related to showering and choice of clothing. The Facility's Ambassadors with their assigned resident group will conduct visits at least three times per week for six weeks and then at least weekly thereafter. Ambassadors will ensure residents' preferences and choices are honored and will identify concerns regarding preferences and choices and ensure timely reporting to Director of Nursing and/or Administrator so that resolution can be accomplished. The Administrator will review Resident Council minutes on a monthly basis to identify concerns regarding honoring preferences and choices such as choice of clothing and provision "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 provisions of federal and state law."	6/22/11

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F 242	Continued From page 7 lift sling above the bed. LN #1 explained NA #2 and NA #3 informed her Resident #1 was upset because she did not want to take a shower. The staff attempted to pivot and transfer the resident but had to lower her to the floor. Interview with NA #2 on 5/10/11 at 4:20 PM revealed Resident #1 refused the transfer to the shower chair and did not want a shower without socks on her feet. When the resident made that statement, NA #2 explained she did not reply to Resident #1 and began the transfer her with NA #3's assistance. NA #2 reported Resident #1 began to cry. NA #2 explained Resident #1 made choices in her care but a shower was scheduled and Resident #1 usually refused showers. Interview with NA #3 on 5/11/11 at 9:59 AM revealed NA #2 requested her assistance with Resident #1's transfer on 4/27/11. NA #3 reported she was not aware of Resident #1's refusal of shower or transfer on 04/27/11. Interview with Minimum Data Set Coordinator #2 on 5/11/11 at 11:00 AM revealed Resident #1 did not resist care but did not always like to get out of bed. Interview with the Director of Nurses (DON) on 5/26/11 at 3:05 PM confirmed that after 05/11/11 she met with NA #2 and other staff involved in order to fully investigate Resident #1's shower refusal on 04/27/11. The DON explained that during the investigation NA #2 informed her that on 04/27/11 Resident #1 wanted to keep her socks on during the shower, but NA #2 told the resident that she had to remove her socks because they would get wet in the shower. NA #2	F 242	of showers to ensure resolution. The Administrator will review concerns on a daily basis Monday through Friday during the Interdisciplinary Team Meeting. Concerns will be assigned to appropriate department managers for resolution and the Administrator will ensure follow up has been conducted to ensure continued compliance. Orientation education for newly hired nursing staff will include education regarding honoring resident preferences and choices. In July 2011 and at least annually thereafter, licensed nurses and nursing assistants will be inserviced by the Director of Nursing, Unit Manager, or Social Services Director regarding honoring resident preferences and choices. 4. The Administrator and/or Director of Nursing will review minutes, rounds, visit reports and concerns and report patterns/trends to the QA&A Committee weekly for four weeks and monthly thereafter. The QA&A Committee will evaluate "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 provisions of federal and state law."	6/22/11

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F 242	Continued From page 8 stated that she removed the resident's socks and then attempted to transfer the resident from her bed to a shower chair. The DON reported that she expected staff to accept a resident's refusal of a shower because it is their right to refuse care and treatment. The DON added that if a resident should refuse to take a shower staff should inform their charge nurse of the refusal, to approach the resident later to again ask them if they would like to receive a shower and if needed to offer the resident a bed bath as an alternative.	F 242	the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance.	6/22/11
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	F 279 1. Corrective action could not be accomplished for Resident #1. The resident expired on 5/2/11. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the RCMD, MDS Coordinator, Administrator, Unit Coordinator, Therapy Program Manager, and/or Director of Nursing have completed an audit of resident transfer evaluations, care plans related to transfers and fall prevention interventions, and CNA assignment sheets to identify discrepancies. Any discrepancies were corrected upon identification. The Rehab "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 provisions of federal and state law."	6/22/11

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F 279	Continued From page 9 Based on staff interviews and record review the facility failed to develop a comprehensive care plan to include method of transfer and interdisciplinary referral for Physical Therapy for one (1) of four (4) sampled residents with falls. (Resident #1) The findings are: Resident #1 was admitted on 03/31/11 with diagnoses of osteoarthritis, high blood pressure and chronic obstructive pulmonary disease. A review of the nursing admission assessment dated 03/31/11 revealed Resident #1 required extensive assistance with two plus persons physical assistance with transfers, was unsteady with surface to surface transfers and was non-ambulatory. The resident's 03/31/11 admission physician's orders revealed an order for a physical therapy evaluation. A review of Resident #1's 04/05/11 "Fall Risk" assessment specified she was at high risk for falls. A review of Resident #1's "Transfer Evaluation," completed by nursing staff on 04/05/11, revealed she was non-ambulatory, none/no weight bearing, confused, followed simple directions, unable to sit on bedside without full back support and had osteoporosis/arthritis. This evaluation specified that Resident #1 required "caregiver performs 100 percent of the task with mechanical lift (total body/sling lift)." The admission Minimum Data Set (MDS) dated 04/07/11 indicated Resident #1 had short term and long term memory problems, moderately	F 279	Program Manager has conducted an audit to include current residents who had orders for therapy intervention. Any discrepancies were corrected upon identification. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Interdisciplinary Team (IDT) (RCMD, MDS Coordinator, Activities Director, Food Service Director, Therapy Program Manager, Administrator, Director of Nursing, Unit Coordinator,and/or Social Services Director) were inserviced by the Regional Care Management Coordinator on 6/16/2011 and 6/20/2011 regarding completion of comprehensive care plans based on resident assessment and care needs. Rehabilitation staff members were inserviced by Therapy Program Manager on 6/21/11 regarding completion of evaluations per the MD order. The IDT will review new admissions daily Monday through Friday during morning meeting to "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 provisions of federal and state law."	6/22/11

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(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 279	Continued From page 10 impaired cognitive skills for decision making, required extensive assistance with two (2) plus persons physical assist with transfers, was unsteady with surface to surface transfers and did not walk in room or in corridor. A review of Resident #1's Plan of Care, which was initially developed on 04/12/11, contained a "problem" which identified her as being at risk for falls. The care plan's goal specified she would be free of fall related injury through next review. Interventions on the resident's care plan did not specify how she was to be transferred by staff, did not specify "appropriate footwear" as being non-skid shoes and/or non skid socks and there was no documentation in the section for Interdisciplinary referral for Physical Therapy services. A review of Resident #1's Nursing Assistant (NA) instruction sheet dated 4/15/11 under the heading for transfer and assist specified two plus person assist and maxi (full body) lift. A review of Resident #1's Care Area Assessment (CAA) Summary dated 04/20/11 revealed the resident "triggered" for further review in the care area of "Falls." The resident's "Falls" CAA specified, "Resident is at risk for falls, is dependent for all transfers, unable to bear weight, is medicated routinely with a narcotic for pain, has dx (diagnosis) depression and is medicated daily for symptoms, requires extensive assist for most mobility, is O2 (oxygen) dependent with poor endurance." No referral for Physical Therapy was noted on the resident's Care Area Assessments or on her plan of care.	F 279	identify orders for therapy evaluation, initial assessment data and interim care plans. The Therapy Program Manager will monitor completion of therapy evaluations per the physician's order weekly for four weeks and then monthly thereafter. The RCMD or MDS Coordinator will monitor the completion of transfer evaluations and appropriate care plan updates related to transfers for new admissions and residents who exhibit a change in their transfer ability status weekly for four weeks and then at least quarterly based upon the MDS assessment schedule to ensure continued compliance. 4. The RCMD and/or MDS Coordinator and Therapy Program Manager will review data obtained during audits and monitors and report patterns/trends to the QA&A committee monthly. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative "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 provisions of federal and state law."	6/22/11

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F 279	Continued From page 11 A review of the nurse's notes dated 04/27/11 revealed Resident #1 was "lowered to the floor" by NA #2 and NA #3 during a transfer. A review of the emergency medical services transfer report dated 04/27/11 revealed Resident #1 was transferred to a hospital at 8:13 p.m. A review of Resident #1's Hospital Admission History and Physical of 04/27/11 revealed admitting diagnoses which included; acute fracture of left tibial plateau, stroke and aspiration pneumonia. An interview on 05/11/11 at 10:40 a.m. with MDS Coordinator #2 revealed when completing Resident #1's Admission Comprehensive Assessment she was aware Resident #1 was extensive assist but she never observed Resident #1 while being transferred and was not sure if a lift was used. Further interview with MDS Coordinator #2 on 05/26/11 at 10:15 a.m. she stated if care areas are triggered on the MDS then a care plan would be developed if needed and if not needed would be documented on the CAA. She further explained she was unaware of Resident #1's physician's order dated 03/31/11 for a Physical Therapy evaluation. She stated she should have been aware of this order and should have noted a PT referral on Resident #1's Care Area Assessment (CAA). MDS Coordinator #2 confirmed the physical therapy component on Resident #1's care plan should have been checked for PT services, and standard practice in the facility was to use non-skid socks as proper footwear and should have been indicated on the care plan.	F 279	outcomes identified to ensure continued compliance. "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 provisions of federal and state law."	6/22/11

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F 279	Continued From page 12 During an interview on 05/26/11 at 10:37 a.m. the Director of Nursing (DON) demonstrated "gripper" socks used by the facility and stated she considered proper footwear was use of non-skid shoes or the non-skid "gripper" socks. She stated it was her expectation that proper footwear identified on Resident #1's care plan should have been specific to include non-skid shoes or gripper socks, and staff should have had some type of non-skid footwear on Resident #1 when transfer occurred. An interview with the facility's Physical Therapist (PT) on 05/26/11 at 12:00 p.m. revealed she was not informed of Resident #1's 03/31/11 admission order for a PT evaluation to be completed. The PT explained had she been made aware of this physician's order she would have observed the resident's physical capabilities, including her ability to transfer, and made a determination of her need to receive PT services.	F 279		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review, the facility staff failed to do a comprehensive assessment and provide	F 309	F309 1. Residents identified to be affected by the alleged deficient practice. Resident #1 transferred to Iredell Memorial Hospital on April 27, 2011 at 8:13 pm related to acute changes in her clinical status. This resident expired on May 2, 2011; therefore, no further "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 13 emergency medical services for one (1) resident of nine (9) sampled residents following a significant change in her condition (Resident #1). Resident #1 was moved by staff after a fall and prior to being assessed by licensed nursing. Licensed nursing failed to complete a thorough assessment of the resident when notified of the fall and again when Resident #1 presented symptoms of difficulty breathing, diaphoresis, and impaired speech. Immediate jeopardy began on 4/27/11 when staff lowered Resident #1 to the floor during a transfer. Immediate jeopardy was removed on 5/27/11 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee education. The findings are: Review of the facility's Changes in Resident Condition policy revised June 2008 revealed "for life threatening emergencies call 911 if initial assessment indicates that such action is necessary." Resident #1 was admitted on 03/31/11 with diagnoses of osteoarthritis, high blood pressure and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) dated 4/7/11 revealed Resident #1 required the extensive assistance of two persons for transfers and was non ambulatory. The	F 309	corrective action could be accomplished. On April 29, 2011 the facility's Director of Nursing began an investigation into the facts surrounding the resident's discharge on April 27, 2011. The investigation continued until 5/17/11 when the four employees involved were interviewed and pertinent documents were reviewed. This investigation included details regarding the discharge of Resident #1 on April 27, 2011. Director of Nursing provided one: one education in regards to utilizing assignment sheets, transfer techniques, communicating with supervisors regarding change in condition including incidents such as a resident being lowered to the floor and completion of change of condition forms, and counseling to three employees as appropriate. "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 14 admission MDS coded the resident with short and long term memory problems with no behavior problems. The MDS assessment coded Resident #1 could make herself understood and understood others. The MDS marked no impairment in functional limitation of range of motion. Review of nursing notes dated 4/27/11 at 6:00 PM revealed Licensed Nurse (LN) #1 documented a skin tear was noted on Resident #1's inner left arm while staff lowered her to the floor during a transfer at 4:00 PM. LN #1 documented Resident #1 refused supper, was upset and "not communicating well." Review of a facsimile dated 4/27/11 sent at 6:20 PM revealed LN #1 requested Ativan 1 milligram (for anxiety) because Resident #1 was "upset with staff who tried to give her a shower." This facsimile also notified the physician of the fall and resultant skin tear. Review of nursing notes dated 4/27/11 at 7:15 PM revealed LN #1 documented Resident #1 experienced garbled speech, a pulse of 114, vomiting and an O2 sat level of 73-74%. The O2 sat level rose to 78% after an oxygen increase to 4 - 5 L/min and administration of a nebulizer treatment then returned to 73%. LN #1 documented two phone calls to the physician on call, family notification and Director of Nursing notification. Resident #1 was sent to the emergency room. Review of the Emergency Medical Services (EMS) Transport record revealed an emergency call placed from the facility at 7:44 PM on 4/27/11	F 309	On 5/4/2011- 5/7/2011, the Unit Coordinator educated all licensed nurses regarding assessment of a resident specifically related to falls, assessments in relation to change of condition and reporting. One exception was a PRN nurse who was educated on May 18, 2011. On May 4, 2011, all available Certified Nursing Assistants were educated on utilizing assignment sheets, transfer techniques, communicating with supervisors regarding change in condition including incidents such as a resident being lowered to the floor and completion of Change of Condition forms. There were three outlying Certified Nursing Assistants that were educated by May 11, 2011. Starting the week of May 9, 2011 the facility Quality Assessment and Assurance Committee met weekly for three weeks to review actions associated with change in resident status. Going forward, the Quality Assessment and "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 15 for Resident #1. Review of the EMS Transport record dated 4/27/11 revealed an initial assessment of Resident #1 at 7:56 PM. Resident #1 was unresponsive and in respiratory distress. The report listed flaccidity of all extremities, weak pulse of 113, blood pressure of 91/41, shallow respirations of 22 with an O2 sat level of 73%. Review of Resident #1's hospital admission history and physical dated 4/27/11 revealed the admission diagnoses of aspiration pneumonia, acute fracture of the left tibia plateau, and probable cerebral vascular accident (CVA). Resident #1 expired on 5/2/11. Interview with Licensed Nurse (LN) #1 on 5/10/11 at 3:45 PM revealed she heard Resident #1 crying on 4/27/11 during her afternoon medication pass "about 4:00 or 4:15 PM." LN #1 explained she administered medications to two other residents and entered Resident #1's room. LN #1 stated Resident #1 was sitting in a total lift sling and was positioned above the bed. LN #1 reported she asked Nursing Assistant (NA) #2 and NA #3 why Resident #1 was crying. She stated that Resident #1 did not usually cry. It was at this time, NA #2 reported the resident started to slide when they were manually transferring her. They lowered Resident #1 to the floor and saw a skin tear. LN #1 explained she informed NA #2 and NA #3 she would assess Resident #1 after they completed her care which included a bed bath after transfer. LN #1 reported she initially observed Resident #1 in the sling with a visual check of the legs. LN #1 reported she also visually assessed Resident #1's legs for swelling	F 309	Assurance Committee will meet monthly or as needed. 2. Residents with the potential to be affected by the alleged deficient practice. Residents who exhibit acute changes in condition requiring intervention, such as hospitalization, have the potential to be affected by the alleged deficient practice. On 5/26/11, the Director of Nursing identified eight current residents who had an acute change in condition requiring hospitalization in the last 30 days. In addition, on 5/27/2011, the Director of Nursing began a review of the current residents who have had an acute change in condition requiring intervention and residents who have expired in the last 30 days. On 5/27/11, the Director of Nursing audited the corresponding documentation in the medical records of these residents to determine that a nursing assessment was done and interventions were implemented. Items identified as a result of the audit were followed-up on as appropriate. "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 16 and broken areas after the bed bath. Interview with NA #2 on 5/10/11 at 4:20 PM revealed she did not notify LN #1 after lowering Resident #1 to the floor because this was not a fall. NA #2 explained LN #1 came into the room during the resident ' s transfer in the sling back to bed. NA #2 revealed she informed LN #1 of lowering the resident to the floor. NA #2 reported LN #1 said she would fully assess Resident #1 after the NAs transferred her to bed and completed the bed bath. Interview with NA #3 on 5/11/11 at 9:59 AM revealed she and NA #2 lowered Resident #1 to the floor during a transfer from bed to shower chair on 4/27/11. NA #3 reported she did not immediately notify LN #1. NA #3 explained she decided it would be better to provide incontinence care before the nurse could assess her. NA #3 added she thought Resident #1 should be clean prior to the assessment. Interview with MDS Coordinator #1 on 5/11/11 at 10:38 AM revealed she was informed by LN #1 of Resident #1's change in condition and calls placed to the on call physician. MDS Coordinator #1 reported she assisted with the transfer papers to the hospital and did not assess Resident #1. Interview with the Director of Nursing (DON) on 5/11/11 at 2:00 PM revealed she expected nursing assistants to notify the charge nurse immediately after a fall. The DON explained an assessment should be made in order to determine the safety of moving a resident and to determine if emergency measures were required.	F 309	3. Systemic Measures On 5/27/2011, facility initiated reinforcement of the facility's practice for the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator, Resident Care Management Director, and MDS Coordinator) reviews on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate. Adjustments to the plan of care and Care Assignment Sheets will be made based on these reviews and the input of medical professionals. On May 27, 2011, the facility initiated provisions to account for weekend review of the 24-hour report, incidents and changes in condition by the manager on duty and/or charge "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 17 An interview with LN #1 on 5/25/11 at 4:05 PM revealed she did not assess Resident #1's range of motion after the transfer back to bed because she observed Resident #1 "pull up" both legs. LN #1 reported Resident #1 was not coherent as normal. LN #1 revealed she applied a dressing on a skin tear of the left forearm but did not perform a full physical assessment because she thought the resident was upset about the transfer. Continued interview at this time with LN #1 revealed she saw Resident #1's uneaten supper tray in the room approximately "around 5:30 PM or so" and observed the resident who remained upset. LN #1 reported she faxed the physician a request for an Ativan (a medication for anxiety). LN #1 explained Resident #1 became short of breath and vomited when she checked approximately "10 or 15 minutes later." In response, she increased the oxygen to 4 or 5 L/min because of an O2 sat in the low 70s, called LN #4 for a nebulizer machine, placed a call to the physician and notified the resident's family. LN #1 reported she placed a second call to the physician approximately 15 minutes after the first call when Resident #1's O2 sat remained in the low 70's after the nebulizer treatment. LN #1 explained she called 911 because the physician had not called back after two calls and Resident #1 continued to have trouble breathing. LN #1 (a Licensed Practical Nurse) explained she did not ask LN #4 (a Registered Nurse) or MDS Coordinator #1 (a Registered Nurse) because of her longevity as a nurse and own nursing skills. Interview with the Director of Nursing on 5/25/11 at 5:05 PM revealed she expected a full assessment to be conducted immediately after a	F 309	nurse. The DON or Administrator will be called to discuss findings and initiate further action as appropriate. On 5/26/2011, the Regional Clinical Director and the Director of Nursing conducted training with all scheduled licensed nurses regarding what constitutes a nursing assessment, post-change of condition assessment, use of Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition. The Interact II tool is used for the identification of change in condition, communication of those changes and continuity of care. All licensed nursing staff will be provided this education via the Director of Nursing or Resident Care Management Director prior to being allowed to work. This education will be included in the facility's new hire orientation. "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 18 fall including passive range of motion, vital signs and a pain assessment. The DON revealed 911 should be called when the physician could not be reached and a resident required immediate medical attention. Interview with the Administrator on 5/26/11 at 8:55 AM revealed she obtained confirmation of pages to the on call physician on 4/27/11 at 7:13 PM and 7:35 PM for Resident #1. Interview with LN #4 on 5/26/11 at 2:50 PM revealed she brought the nebulizer machine and mask into Resident #1's room "between 6:30PM and 6:45 PM." LN #4 reported she did not assess Resident #1 and described Resident #1 "having trouble breathing, pale and sweating and making noise like a chant." LN #4 reported Resident #1 vomited prior to nebulizer treatment. LN #4 reported she was at the nursing desk "about 10 minutes later" when LN #1 asked her to check the O2 sat after the nebulizer treatment. LN #4 stated Resident #1 "was still pale, sweating and having trouble breathing." LN #4 revealed she reported to LN #1 Resident #1's O2 sat was "in the low 70's" at which time LN #1 called 911. Interview with Resident #1's physician on 5/26/11 at 1:20 PM revealed she expected the facility nurse to conduct a full assessment after a resident fall. This assessment would include a pain assessment in addition to testing all extremities for joint movement. The physician explained 911 should be called in acute situations if the physician did not call back within 5 minutes. The Administrator was informed of Immediate Jeopardy on May 26, 2011 at 4:22 PM for	F 309	Beginning May 27, 2011, scheduled Certified Nursing Assistants were educated regarding notification of the Nurse when a resident experiences a change in condition, including but not limited to respiratory difficulty, mental status changes and falls. CNA's will be provided this education via the Director of Nursing or Resident Care Management Director prior to being allowed to work. In addition, on May 27, 2011 the facility's grand rounds process, which includes Director of Nursing, Resident Care Management Director and/or Unit Coordinator, increased the frequency of the grand rounds to at least three times per week for the next four weeks to include observations, discussion with four randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 19 Resident #1. The facility presented a credible allegation of compliance which included: 1. Residents identified to be affected by the alleged deficient practice. Resident #1 transferred to (name) Hospital on April 27, 2011 at 8:13 pm related to acute changes in her clinical status. This resident expired on May 2, 2011; therefore, no further corrective action could be accomplished. On April 29, 2011 the facility's Director of Nursing began an investigation into the facts surrounding the resident's discharge on April 27, 2011. The investigation continued until 5/17/11 when the four employees involved were interviewed and pertinent documents were reviewed. This investigation included details regarding the discharge of Resident #1 on April 27, 2011. Director of Nursing provided one: one education in regards to utilizing assignment sheets, transfer techniques, communicating with supervisors regarding change in condition including incidents such as a resident being lowered to the floor and completion of change of condition forms, and counseling to three employees as appropriate. On 5/4/2011- 5/7/2011, the Unit Coordinator educated all licensed nurses regarding assessment of a resident specifically related to falls, assessments in relation to change of condition and reporting. One exception was a PRN nurse who was educated on May 18, 2011. On May 4, 2011, all available certified nursing	F 309	appropriate, and interventions being implemented to address the resident's need. Grand Rounds were conducted on 5/27/2011 by the Director of Nursing and Regional Clinical Director. Twelve residents were reviewed to assess for additional needs and interventions. The Director of Nursing and Regional Clinical Director also reviewed the documentation in the medical records of these residents to ensure identification of acute changes of condition and notification of physician. Necessary follow-up was completed and there are no outstanding concerns. 4. Quality Assessment and Assurance On May 26, 2011, the Quality Assessment and Assurance Committee, including the facility Administrator, Human Resources Coordinator, Director of Nursing, Resident Care Management Director, MDS Coordinator, Maintenance Director, Social Worker, Activities Director, "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 provisions of federal and state law."	6/22/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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(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 309	Continued From page 20 assistants were educated on utilizing assignment sheets, transfer techniques, communicating with supervisors regarding change in condition including incidents such as a resident being lowered to the floor and completion of change of condition forms. There were three outlying Certified Nursing Assistants that were educated by May 11, 2011. Starting the week of May 9, 2011 the facility Quality Assessment and Assurance Committee met weekly for three weeks to review actions associated with change in resident status. Going forward, the Quality Assessment and Assurance Committee will meet monthly or as needed. 2. Residents with the potential to be affected by the alleged deficient practice. Residents who exhibit acute changes in condition requiring intervention, such as hospitalization, have the potential to be affected by the alleged deficient practice. On 5/26/11, the Director of Nursing identified eight current residents who had an acute change in condition requiring hospitalization in the last 30 days. In addition, on 5/27/2011, the Director of Nursing began a review of the current residents who have had an acute change in condition requiring intervention and residents who have expired in the last 30 days. On 5/27/11, the Director of Nursing audited the corresponding documentation in the medical records of these residents to determine that a nursing assessment was done and interventions were implemented. Items identified as a result of the audit were followed-up on as appropriate.	F 309	Therapy Program Manager, Medical Records Coordinator, Medical Records Assistant, Scheduler, Unit Coordinator, Dietary Manager to discuss the acute episode experienced by Resident #1 on 4/27/2011. The Committee also has reviewed this acute episode with the facility's Medical Director. On 5/26/2011, the Committee has reviewed the education materials provided to the licensed nursing staff regarding identification of change in condition, nursing assessment, and initiation of interventions based on assessment findings. Additional measures put into place to ensure the alleged deficient practice does not recur include: The Interdisciplinary Team(IDT) will review incident/accidents on a daily basis Monday through Friday during the IDT Meeting to ensure any change in condition is identified. Care plan updates and changes to the CNA assignment sheets will "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 21 3. Systemic Measures On 5/27/2011, facility initiated reinforcement of the facility's practice for the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator, Resident Care Management Director, and MDS Coordinator) reviews on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate. Adjustments to the plan of care and Care Assignment Sheets will be made based on these reviews and the input of medical professionals. On May 27, 2011, the facility initiated provisions to account for weekend review of the 24-hour report, incidents and changes in condition by the manager on duty and/or charge nurse. The DON or Administrator will be called to discuss findings and initiate further action as appropriate. On 5/26/2011, the Regional Clinical Director and the Director of Nursing conducted training with all scheduled licensed nurses regarding what constitutes a nursing assessment, post-change of condition assessment, use of Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition. The Interact II tool is used for the identification of change in condition, communication of those changes and	F 309	be made based on these reviews. The Director of Nursing, RCMD, and/or Unit Coordinator will review 24-hour reports daily, Monday through Friday, to identify any change in resident's condition. On weekends, charge nurses will contact Director of Nursing and/or Administrator for significant incidents such as falls with significant injuries to discuss additional information and potential interventions. Care plan updates and changes to the CNA assignment sheets will be made based on these reviews. On 5/17/2011 and 5/19/2011, the three identified staff members were provided re-education and counseling as appropriate as indicated in the Credible Letter of Allegation. Grand Rounds as indicated in the Credible Letter of Allegation will continue after the four week period at least weekly on an ongoing basis. Additionally, the licensed nurses will be inserviced in September 2011 and annually thereafter on nursing assessment, post-change of condition assessment, use of "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 22 continuity of care. All licensed nursing staff will be provided this education via the Director of Nursing or Resident Care Management Director prior to being allowed to work. This education will be included in the facility's new hire orientation. Beginning May 27, 2011, scheduled Certified nursing assistants were educated regarding notification of the nurse when a resident experiences a change in condition, including but not limited to respiratory difficulty, mental status changes and falls. Certified Nursing Assistants will be provided this education via the Director of Nursing or Resident Care Management Director prior to being allowed to work. In addition, on May 27, 2011 the facility's grand rounds process, which includes Director of Nursing, Resident Care Management Director and/or Unit Coordinator, increased the frequency of the grand rounds to at least three times per week for the next four weeks to include observations, discussion with four randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as appropriate, and interventions being implemented to address the resident ' s need. Grand Rounds were conducted on 5/27/2011 by the Director of Nursing and Regional Clinical Director. Twelve residents were reviewed to assess for additional needs and interventions. The Director of Nursing and Regional Clinical Director also reviewed the documentation in the medical records of these residents to ensure identification of acute changes of condition and notification of physician. Necessary follow-up was completed and there are no outstanding concerns.	F 309	Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition to ensure continued compliance. The Administrator and/or Director of Nursing will review data obtained during reviews and report patterns/trends to the QA&A Committee weekly for four weeks and monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 provisions of federal and state law."	6/22/11

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F 309	Continued From page 23 4. Quality Assessment and Assurance On May 26, 2011, the Quality Assessment and Assurance Committee, including the facility administrator, Human Resources Coordinator, Director of Nursing, Resident Care Management Director, MDS coordinator, maintenance director, social worker, activities director, therapy program manager, medical records coordinator, medical records assistant, scheduler, unit coordinator, dietary manager to discuss the acute episode experienced by resident #1 on 4/27/2011. The Committee also has reviewed this acute episode with the facility ' s medical director. On 5/26/2011, the Committee has reviewed the education materials provided to the licensed nursing staff regarding identification of change in condition, nursing assessment, and initiation of interventions based on assessment findings. Immediate jeopardy was removed on May 27, 2011 at 6:50 PM with interviews of direct care and licensed nursing staff who confirmed they received in-service training on 5/27/11 prior to reporting on duty. Interviews with nursing staff revealed awareness of how to respond to a resident ' s change in condition. Nursing assistants interviewed reported direction to notify a licensed nurse immediately after a fall which included lowering to the floor. Licensed Nurses interviewed described the components of a nursing assessment and	F 309		

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F 309	Continued From page 24 direction to call 911 when a resident required emergency medical attention. Record review of sampled residents revealed documentation of transfer assessments and documentation of nursing assessments. Observations revealed guidance tools for resident assessment available for staff use.	F 309		
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 record review and staff interviews the facility failed to safely transfer one (1) of four (4) sampled residents. (Resident #1) Staff transferred Resident #1 without using the maxi lift or wearing footwear to prevent sliding. The findings are: Resident #1 was admitted on 03/31/11 with diagnoses of osteoarthritis, high blood pressure and chronic obstructive pulmonary disease. Resident #1's admission Minimum Data Set (MDS) dated 04/07/11 specified that she had short term and long term memory problems, moderately impaired cognitive skills for decision making, required extensive assistance with two	F 323	F323 1. Corrective action could not be accomplished for Resident #1. The resident expired on 5/2/11. NA#2 and NA#3 have been re-educated and counseled regarding transfer techniques to assure strict adherence to facility transfer procedures. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the RCMD, MDS Coordinator, Administrator, Unit Coordinator, Therapy Program Manager, and/or Director of Nursing have completed an audit of resident transfer evaluations, care plans, and CNA assignment sheets to identify concerns regarding accuracy of information. Any concerns were corrected upon identification. The "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 provisions of federal and state law."	6/22/11

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F 323	Continued From page 25 (2) plus persons physical assist with transfers, was unsteady with surface to surface transfers, did not walk in room or in corridor could make herself understood and understood others. A review of the admission physician's orders dated 03/31/11 revealed an order for a physical therapy evaluation. A review of the "Fall Risk" assessment completed on 04/05/11 specified that Resident #1 was at high risk for falls. Interview with the facility's Physical Therapist (PT) on 05/26/11 at 12:00 p.m. revealed PT was not notified by nursing services that Resident #1 had a 03/31/11 physician's order for an initial screening. The therapist explained if she had been made aware of this order the resident's abilities, including transferring, would have been observed in order to see if she could benefit from physical therapy services and what was the safest way for her to be transferred. A review of a Resident Transfer Evaluation dated 04/05/11 and signed by a Licensed Nurse (LN) revealed Resident #1 required "caregiver performs 100 percent of the task with mechanical lift (total body/sling lift)." A review of Care Area Assessment (CAA) Summary dated 04/20/11 revealed Resident #1 was "triggered " for further review in the care area of "Falls." The resident's "Falls" CAA specified, "Resident is at risk for falls, is dependent for all transfers, unable to bear weight, is medicated routinely with a narcotic for pain, has dx (diagnosis) depression and is medicated daily for symptoms, requires extensive assist for most mobility, is O2 (oxygen) dependent with	F 323	Resident Care Management Director (RCMD), MDS Coordinator, or admitting licensed nurse will complete transfer evaluation reviews upon admission, quarterly, annually, and with significant change in status based on the MDS assessment schedule. The Interdisciplinary Team has audited the last three months of incidents to identify any residents with injuries related to staff-assisted transfer to ensure the transfer evaluation reviews, care plans and CNA assignment sheets were updated correctly. The Director of Nursing, Resident Care Management Director, MDS Coordinator and/or Unit Supervisor has initiated skills validations for safe transfer techniques for CNAs and licensed staff. An onsite meeting with a representative from the Carolina's Center for Medical Excellence (CCME) was conducted on 6/17/11 to review the plan of correction for 483.25 (Supervision to Prevent Accidents). Suggestions for the "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 provisions of federal and state law."	6/22/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 26 poor endurance." No referral for Physical Therapy was noted on the resident's Fall CAA. A review of the care plan updated on 04/12/11 contained a "problem" which identified Resident #1 as being at risk for falls. The care plan's goal specified she would be free of fall related injury through next review. Interventions on the care plan included; ensure resident has proper footwear as indicated and accepted. The resident's care plan did not address how staff was to specifically transfer the resident. A review of Resident #1's Nurse/NA Assignment/Care Plan Sheet dated 4/15/11 under the area of transfers specified two person assist and maxi lift. A review of a "SSC - Transfer Report" from 03/31/11 until 04/27/11 revealed Resident #1 was transferred by different methods including thirty-four (34) occurrences of two (2) plus person assist; eighteen (18) occurrences of stand/assist lift; thirteen (13) occurrences of full body/sling lift and two (2) occurrences with gait belt/sliding board. A review of nurse's notes of 04/27/11 revealed the following entries: 04/27/11 at 6:00 p.m. Resident #1 became upset when she was told by nursing assistants she would get a shower. During a transfer Resident #1 received a medium sized skin tear to inner left arm while " lowered to the floor " with two (2) staff members present. Resident #1 was asked if she was in pain or discomfort but her speech was unclear.	F 323	plan were reviewed and implemented as appropriate. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Director of Nursing, Resident Care Management Director, or Unit Coordinator will complete inservice training for nursing staff regarding supervision to prevent accidents, specifically, regarding transfer techniques and following C.N.A. assignment sheets. Orientation education for newly hired certified nursing assistants will include education regarding proper transfer technique and skills validation. Additionally, transfer skills validations will be completed at the rate of five per month ongoing for randomly selected CNA's as part of the facility's ongoing Safety Committee process through QA&A to ensure continued compliance. The IDT will review incidents/accidents daily Monday through Friday during morning meeting to identify any issues with transfer technique and "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 provisions of federal and state law."	6/22/11

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F 323	Continued From page 27 A review of the emergency medical services transfer report dated 04/27/11 revealed Resident #1 was transferred to the hospital at 8:13 p.m. A review of the Hospital Admission History and Physical of 04/27/11 revealed admitting diagnoses for Resident #1 which included; acute fracture of left tibial plateau, stroke and aspiration pneumonia. An interview on 05/10/11 at 2:10 p.m. with Resident #1's physician revealed Resident #1 had not walked in a couple years and she required two people to assist her with transfers. An interview on 05/10/11 at 3:00 p.m. with an orthopedic surgeon who had reviewed the x-ray of Resident #1's left leg revealed that the resident's fracture appeared to be a crunching type injury without a lot of soft tissue injury and when she went down into the floor a hyper-flexion of her leg was enough force to cause a fracture. The surgeon stated that the bruising could have been minimal since there was not a lot of soft tissue damage. An interview with Licensed Nurse (LN) #1 on 05/10/11 at 3:47 p.m. revealed that on 04/27/11 at approximately 4:15 p.m. she heard Resident #1 crying and she went into the resident's room. LN #1 explained that when she entered the room she observed Resident #1 sitting in a full body lift. LN #1 explained that she was first informed by NA #2 and NA #3 at this time Resident #1 had to be lowered to the floor when she began to slide downward as they attempted to manually transfer her from her bed to a shower chair and they were	F 323	additional interventions needed based on the needs of the residents. On weekends, charge nurses will contact Director of Nursing and/or Administrator for significant incidents such as falls with significant injuries to discuss additional information and potential interventions. 4. The Administrator and/or the Director of Nursing will review audits and incidents/accidents and report patterns/trends to the QA&A Committee weekly for four weeks and monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 provisions of federal and state law."	6/22/11

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F 323	Continued From page 28 now transferring her back to bed. LN #1 confirmed she was aware that Resident #1 was supposed to always be transferred with a lift. An interview with Nursing Assistant (NA) #2 on 05/10/11 at 4:00 p.m. revealed on 04/27/11 at approximately 4:30 p.m. she and NA #3 attempted to manually transfer Resident #1 from her bed to a shower chair. NA #2 explained when performing this manual transfer she was holding under the resident's right arm and NA #3 was holding under the resident's left arm. As they assisted Resident #1 to stand up she began to slide off the bed and she had an episode of diarrhea. NA #2 stated as the resident began to slide downward, they were unable to hold Resident #1 up, so they lowered her to the floor. NA #2 stated that Resident #1 was sitting on the floor with her right leg and left leg bent next to the side of her body. NA #2 stated NA #3 straightened the resident's legs out, laid her down flat on the floor and put pillows under her head. NA #2 explained she observed a skin tear on the resident's left arm. Further interview with NA #2 on 05/25/11 at 4:35 p.m. revealed she did not use a lift when transferring Resident #2 from her bed to the shower chair on 04/27/11 because a lift was not available. NA #2 explained prior to performing this transfer Resident #1 was wearing either socks or slippers which had a hard rubber (non skid) material on the bottom. NA #2 stated Resident #1 said she wanted to keep her socks on while taking a shower, but she told the resident she could not wear them because they would get wet. NA #2 stated she took Resident #1's socks/slippers off prior to the manual	F 323		

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F 323	Continued From page 29 transfer, so the resident did not have anything on her feet during the transfer and while being lowered to the floor. During an interview on 05/11/11 at 10:00 a.m. NA #3 stated Resident #1 was always a two (2) person transfer with one person under each arm to stand and pivot her. NA #3 stated that on 04/27/11 NA #2 asked her to help transfer Resident #1 from her bed to a shower chair. NA #3 explained they sat Resident #1 up on the side of the bed and as they started to assist her to stand up her knees bent; she had an episode of diarrhea and began to slide downward. They decided to lower her down onto the floor. NA #3 stated Resident #1 sat down on her buttocks but did not recall the position of her legs. NA #3 further stated they placed the resident on her side with one leg on top of the other, straightened her legs out and provided incontinence care. NA #3 stated she noted Resident #1 had a skin tear on her arm. Further interview with NA #3 on 05/25/11 at 2:10 p.m. revealed that on 04/27/11 Resident #1 had socks on her feet and requested for them to be left during her shower, but they were removed by NA #2 prior to transferring from her bed to the shower chair. NA #3 stated on 04/27/11 Resident #1 was in her bare feet when she was manually transferred and had to be lowered to the floor. NA #3 explained LN #1 was not informed of this incident until she entered Resident #1's room and saw her sitting in a maxi-lift. This was following the resident receiving incontinence care and before they transferred her back to bed. An interview on 05/11/11 at 10:46 a.m. with MDS Coordinator #2 she stated the Nurse Aide (NA)	F 323		

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F 323	Continued From page 30 assignment sheets are based on an initial nursing evaluation and are updated at the interdisciplinary team meeting each morning. An interview on 05/11/11 at 2:00 p.m. with Director of Nurses (DON) revealed NA #2 and NA #3's decision to transfer Resident #1 without the lift was an option they had to transfer Resident #1 with two person assist or use the Maxi lift. During further interview with the DON on 05/25/11 at 5:00 p.m. it was revealed that Resident #1's 03/31/11 physician's order for Physical therapy (PT) services was not processed correctly by nursing staff, so PT was not notified that Resident #1 needed to be evaluated. The DON also confirmed that on 04/27/11 staff should have ensured that Resident #1 was wearing proper foot ware, including non skid socks, as specified on her plan of care, before they attempted to transfer her from her bed to a shower chair and needed to be lowered to the floor.	F 323		