PRINTED: 07/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING ___ B. WING ___	C 06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO RIVERS HEALTHCARE - TRENT CAMPUS	836 HOSPITAL DRIVE NEW BERN, NC 28560

AUG 04 2011

(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 record review, resident and staff interviews, the facility failed to provide a 2-person assistance with repositioning and failed to use half side rails when in bed resulting in a fall from the bed for 1 of 3 (Resident #1) sampled residents reviewed for falls Findings include: Resident #1 was admitted to the facility on 12/6/07 and readmitted to the facility on 12/15/10 with diagnoses to include Diabetes Mellitus, End Stage Renal Disease, History of Cerebrovascular Accident, Arthritis, Right below the Knee Amputation and Left above the Knee Amputation. Review of the resident's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/25/11, identified the resident as being cognitively intact and able to make her needs known based on the Brief Interview for Mental Status (BIMS) assessment. Resident #1 ' s Functional Status was assessed as requiring extensive, two-person physical assistance in bed mobility, which included turning side to side and	F 323	F323 1. Corrective Action: DHS completed education with Nurse #1 on providing 2 person assistance with repositioning for resident #1 on 6/21/2011. Nursing Staff inserviced on providing 2 person assistance with repositioning for resident #1 on 6/21/2011. On 6/20/11, Resident #1's bed with half side rails was returned to her. Her careplan is correct and includes half side rails to assist with bed mobility. 2. Others with Potential to be Affected: By 7/19/2011, a 100% audit of resident careplans will be completed to ensure the accuracy of ADL careplans. By 7/19/2011, a 100% audit of careplans will be completed for all residents with side rails to ensure that the careplan identifies the correct type of side rail and reason for use.	7/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth H. Tayloe	Administrator	8/2/11

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 positioning her body in bed. Resident #1 was also assessed as having impairment on both sides of her upper and lower extremities. Resident #1 was lifted using a mechanical lift and totally dependent on staff for transferring. In reviewing the resident ' s Care Area Assessments worksheet, dated 1/25/11, the following Problem Areas triggered: Falls and ADL (Activities of Daily Living) Potential. Falls triggered due to the resident having difficulty standing and impaired balance during transitions related to her diagnoses of Below the Knee Amputation of the right leg and Above the Knee Amputation of the left leg and a recent stroke. ADLs triggered because the resident needed extensive to total assistance with ADLs related to the bilateral leg amputations and Arthritis in fingers of both hands. Review of Resident #1 ' s most recent Care Plan, dated 5/18/10 and updated most recently on 3/25/11 read that Resident #1 is not independent with daily ADLs and requires total to extensive assistance with daily care. A listed " Approach " to meeting the goal of minimizing further decline in the resident ' s level of independence was " half side rails up when in bed to promote independence with bed mobility. " Review of the Care Plan for Falls, dated 5/18/10 and most recently updated on 3/25/11 read that the resident had a potential for falls and noted on the Care Plan were the words, " Bilat BKA " (bilateral below the knee amputation). Review of Resident #1's CNA (Certified Nursing Assistant) Care Record, used by nursing	F 323	3. Measures/Systemic Changes: On 7/7/11, Nursing Staff inserviced on communicating changes in resident ADLs to Nursing Administration. Nursing Administration inserviced on updating careplans to reflect changes in ADLs. All staff inserviced on a) the types of side rails b) the requirement to follow the resident careplan regarding use and type of side rail. Nurses inserviced on attaining physician orders b) reporting changes on 24 hour report related to side rails c) updating resident careplan for side rails. 4. Monitoring: Monitoring to be completed through weekly random audits by DHS/ADHS/RN Supervisor. Any areas of non-compliance will be corrected at the time of discovery. The findings will be reported to the Administrator immediately and monthly to facility's performance improvement committee for patterns or trends and further interventions will be developed as necessary to ensure continued compliance. Audits will be conducted for a minimum of 90 days, followed by monthly audits until substantial compliance is achieved and maintained for an additional 90 days.	

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F 323	Continued From page 2 assistants (NAs) for resident care needs, revealed the section designated for " Reposition - assist of one; Restraints/Safety Devices - Siderails: half x 2 (times two) head of bed. " A review of the facility Incident Report, dated 6/20/11 at 10:45AM, documented that Resident #1 rolled from the bed to the floor while a treatment was being performed. It read that the resident was placed on her left side by the staff; she was on a low air loss mattress and an electric bed. Also documented was that the resident was holding onto the top rail and lost her balance rolling over the side of the bed. The resident went down on her bilateral stumps of her legs. In a review of the Nursing Notes, dated 6/20/11, documentation revealed that the nurse was called to the resident ' s room and observed Resident #1 sitting on her buttocks on the floor. Further documentation read that during treatment the resident was placed on her left side by staff. The resident lost her balance and rolled over the side of the bed. The note documents that the nurse in the room during the treatment tried to stop the fall, but was unable to do so. Resident #1 complained of pain, the Physician was notified, an X-ray was ordered and pain medication given. Resident #1 was sent to the emergency room for evaluation. Review of the Physician ' s Order Sheet from the hospital, dated 6/21/11, read in part, " Dx: (diagnosis) Closed Right Distal Femur Fracture, non-displaced. Splint at all times. " During an interview with Resident #1 on 6/29/11 at 10:10AM, she stated that on the day of the fall	F 323		

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F 323	Continued From page 3 she was in an electric bed that had smaller, short rails at the top of the bed near to her head. She stated that the bed was pulled away from the wall because when she is rolled over on her left side her right knee would hit the wall if the bed is not pulled away. She stated that she was going to receive treatment to her thigh area and she had been rolled to her left side by the nurse. Resident #1 said that she stated, " I ' m going down, " but the nurse did not understand her and said, " what? " Resident #1 said she stated it again but the nurse must not have understood what I meant. She stated that " it all happened so fast " and the nurse tried to stop me but I hit the floor. She continued by saying she thought she was just rolled over too far and usually she can hold onto the rail. During an interview with Nurse #1 on 6/29/11 at 10:30AM, she stated that on the day of the fall the resident had her bath and she went into the room to do her treatment because she is the only one the resident will allow to do her treatments. She stated that she pulled the bed away from the wall, because that is how the resident likes it during the treatment, and rolled the resident to her left side. She stated she was the only person doing the treatment. She stated the bed was approximately three (3) feet from the wall, a little more than usual. She stated that she was putting cream on the resident ' s back from her neck to her legs when the resident stated, " oh. " The nurse then asked the resident, " what is it? " Nurse #1 stated that ' s when she noticed the resident was " going over the side of the bed. " Nurse #1 stated that at the point she moved quickly to the left hand side of the bed and put her arms around the resident and tried to stop the	F 323		

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F 323	Continued From page 4 fall, but could not. Nurse #1 stated that " because of the resident ' s size there was no way I could stop the fall. I had cream all over my gloves and she was covered in cream. I grabbed her body and let her slide to the ground, but she hit her knees. She really did not have enough support to help hold her and she just rolled out of the bed. " The nurse also stated that Resident #1 usually places her arm over the side rail to help keep her balance while on her side. She stated we could look at the type of bed the resident had when she fell in another resident ' s room. During an observation on 6/29/11 at 10:35AM with Nurse #1 of the type of electric bed that Resident #1 had at the time of the fall on 6/20/11 revealed that the side rails were observed to be made of a white, plastic material and were quarter rails positioned bilaterally at the head of the bed. During an interview with the Administrator on 6/29/11 at 10:45AM she stated that Resident #1 ' s non-electric bed had broke and it was replaced with an electric bed. She stated that if two persons would have been assisting during the treatment the fall could have been avoided. During an interview with NA #1 on 6/29/11 at 11:05AM, she stated that she works with Resident #1 often. She stated that the resident had a non-electric bed with half rails but the bed broke and was switched out to an electric bed with little, white plastic rails at the top of the bed. NA #1 stated that the resident likes the bed pulled away from the wall during care because her knee will hit the wall if it is not pulled away. She further	F 323		

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F 323	Continued From page 5 stated that on the day of the incident, she had given the resident a bath and left her on her back for the nurse. She also stated that Resident #1 is rolled using a draw sheet. During an interview on 6/29/11 at 1:15PM with the Minimum Data Set (MDS) Nurse, she stated that she was unaware that the resident did not have half rails until after the fall. She also stated that she did assess the resident as needing extensive 2-person assistance during care and this should have been placed on the Nursing Assistant care record. The MDS nurse and the surveyor walked to room 103 and observed the size of the electric bed side rails and the MDS Nurse stated that they are much smaller and not in the middle of the bed and could see how Resident #1 could have fallen. During an interview with the Maintenance Department on 6/29/11 at 1:40PM, it was stated that the electric beds have quarter side rails near the head of the bed. During an interview with the Director of Nursing on 6/29/11 at 1:50PM, she stated that Resident #1 had half rails on her crank bed, but that during the time of the fall, Resident #1 had quarter rails on the electric bed. During an interview with the Administrator on 6/29/11 at 1:55PM, she stated that Resident #1 ' s crank bed broke on 6/15/11 and was replaced around 5:00PM that evening with an electric bed. She stated after the fall on 6/20/11 the electric bed was removed from the room and it was replaced with the crank type bed. She stated that the facility identified the difference in the side rail	F 323		

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F 323	Continued From page 6 size after the fall.	F 323		