STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345368	A. BUILDING _____ B. WING _____	C 05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG NURSING CENTER	202 SMOKETREE WAY LOUISBURG, NC 27649

(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=D	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 observation, staff and resident interviews and a review of medical records the facility failed to assure that 1 of 3 residents (Resident #2) received adequate supervision to prevent an accident. Findings: Resident #2 was admitted to the facility on 2/13/12 with diagnoses including Cerebral Vascular Accident, Macular Degeneration and delirium tremors. An undated Fall Risk Assessment indicated that she was at High Risk for falls. The Director of Nursing (DON) on interview on 5/2/12 at 2:55pm stated that this undated Falls Assessment was completed on 2/13/12 as part of the resident ' s admission assessment. The 30 day MDS (Minimum Data Set) assessment dated 3/27/12 indicated that Resident #2 had severe cognitive deficits and required the extensive assistance of 1 person for bed mobility and transfers including toileting.	F 323	**F323** **Standard Disclaimer:** This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. Resident #2 is has been re-evaluated for use of personal alarm and risk for falls. Care plan has been updated. All nursing staff has been in-serviced on appropriate monitoring of personal alarms with attention to toileting residents with alarms. All alarms are noted on MAR for q shift verification by nursing staff. Residents who are at risk for falls and/or fall related injuries are reviewed weekly during Person At Risk weekly mtg. All nursing staff have attended the in-service and DVD review on "Mobility and Safe Movement of the Elderly: Improving your skills to prevent injuries and reduce falls" by Teepa Snow as approved by DHSR. The Interdisciplinary Care Plan Team shall ensure compliance with care plan reviews for residents who have personal alarms and/or incidents/accidents related to falls. Any identified discrepancies shall be remediated.	5/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl Vermulyea RN	Administrator	5/29/12

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG NURSING CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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F 323	Continued From page 1 A plan of care dated 2/22/12 included interventions to address Resident #2 ' s fall risk secondary to impaired functional mobility and impulsive behavior. The interventions included use of a clip alarm to alert staff of attempts to self transfer. Resident #2 was observed on 5/1/12 at 7:20pm. She was in bed with a pressure sensitive alarm in place on the bed and a clip type alarm secured to the wheelchair next to the bed. There was a fall mat in place next to the bed. When she was interviewed on 5/1/12 at 7:48pm she stated that she needed help going to the bathroom and that she had one fall resulting in some hip pain. She could not recall when the fall happened and stated she had only been in the facility for 1 week or so. During an interview on 5/1/12 at 11pm the nurse aide (NA#1) assigned to Resident #2 stated that the resident needed 1 person to assist her to the bathroom. She revealed that there were personal alarms and a fall mat in use for fall prevention. She stated that staff had to make sure the alarms were in use and if the alarm sounded staff had to " immediately respond. " A review of Resident #2 ' s medical record revealed a Nurses Note dated 3/22/12 at 8:40pm that indicated the resident sustained a skin tear of the left thumb with no further information. An Incident Report dated 3/21/12 at 6:20pm indicated that Resident #2 " bumped her left thumb on BR (bath room) door " with a skin tear noted between the top of the knuckle and thumb nail.	F 323	The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent Quality Assurance Committee meeting minutes. Additionally, the Administrator, DON and/or Clinical Coordinator shall report any episodes of non-compliance with Physician recommendations/follow-up identified to Quality Assurance Committee monthly for three months and then quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG NURSING CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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F 323	Continued From page 2 During an interview on 5/2/12 at 10am the NA (NA#2) who had assisted Resident #2 on the evening of 3/21/12 indicated that the resident had removed the clip alarm and transferred herself onto the toilet on 3/21/12. The NA stated that the resident then used the emergency call light in the bathroom to call for assistance. The NA indicated that she was in the next room which is connected to Resident #2 ' s room via the bathroom. She stated that she heard the bathroom call light and responded. She found Resident #2 seated on the toilet and the resident requested help to transfer to the wheelchair. The NA reported that she asked Resident #2 to remain on the toilet for not more then 10 or 15 minutes while she finished caring for the resident in the adjacent room. She then reported that in not quite 10 minutes she returned to assist Resident #2 and found the resident had transferred herself off the toilet out of the bathroom and into her wheelchair. She stated that she then noticed the resident ' s clip alarm lying on the bed and that the resident had blood on her hand. NA#2 reported that she did not hear an alarm because the resident had removed it. She stated that the resident she was caring for in the next room was safely in her bed when she responded to Resident #2 ' s request for help. She stated that when she left Resident #2 seated on the toilet she closed the bathroom door and proceeded to undress and put night clothes on the other resident. She indicated she could not see Resident #2 and that she left her alone on the toilet for not quite 10 minutes. She indicated that she believed Resident #2 had transferred	F 323		

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F 323	Continued From page 3	F 323		

herself into the bathroom and then used the call light to seek assistance out of the bathroom. She reported that she didn't think Resident #2 would try to transfer herself because she had put the call light on for help. She stated that she was trained not to leave residents with personal alarms unattended when in the bathroom.

On 5/2/12 at 11:25pm a Med Aide (MA#1) was interviewed in regard to residents who have personal alarms. She stated that while toileting a resident who had a personal alarm the alarm is turned off and the resident is not to be left alone while in the bathroom.

During an interview on 5/2/12 at 11:28am a NA (NA#3) who has worked at the facility for 2 years stated that residents who have personal alarms are closely supervised when using the bathroom. "We make sure we can see them" while allowing privacy and provide "close supervision."

On interview on 5/2/12 at 11:38am a nurse (LPN#1) who was assigned to Resident #2 indicated that it was the policy of the facility to keep residents with personal alarms "in your vision" when alarms are turned off during bathroom use. She stated that this was done to prevent unassisted transfers.

During an interview on 5/2/12 at 11:50am the NA (NA#4) assigned to Resident #2 stated that when she toileted the resident she remained in the bathroom or in the doorway and kept the resident in her sight "because she will get up unassisted if you leave her."

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F 323	Continued From page 4 On interview on 5/2/12 at 12pm a PTA (physical therapy aide #1) who had worked with Resident #2 from 2/13/12 to 3/28/12 stated that Resident #2 could get up from a bed or chair unassisted. She indicated that the resident when toileted needed someone with her. She stated that the resident was unsafe when turning or reaching for safety bars and that the resident was very inconsistent. She stated that staff " could be in the doorway keeping her in sight but not walk away and leave her unsupervised. " During an interview on 5/2/12 at 12:05pm the DON stated that her expectations would have been that the NA would have assisted Resident #2 from the toilet on the evening of 3/21/12 and then resumed care for the resident who was already in bed. On interview on 5/2/12 at 4:05pm the Administrator stated that when the 3/21/12 incident was reviewed at morning meeting they determined the causal factor to be the resident ' s self transfer. They did not identify that the resident was left unsupervised in a bathroom.	F 323		

F323
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Resident #2 is has been re-evaluated for use of personal alarm and risk for falls. Care plan has been updated.

All nursing staff has been in-serviced on appropriate monitoring of personal alarms with attention to toileting residents with alarms.

All alarms are noted on MAR for q shift for verification by nursing staff.

Residents who are at risk for falls and/or fall related injuries are reviewed weekly during Person At Risk (PAR) weekly mtg.

All nursing staff have attended the in-service and DVD review on "Mobility and Safe Movement of the Elderly, Improving your skills to prevent injuries and reduce falls" by Teepa Snow as approved by DHSR.

The Interdisciplinary Care Plan Team shall ensure compliance with care plan reviews for residents who have personal alarms and/or incidents/accidents related to falls. Any identified discrepancies shall be remediated.

The DON/Administrator and/or designee shall monitor nursing staff weekly for compliance with fall prevention process and the safe monitoring of residents with alarms weekly x 4 weeks and then monthly/prn thereafter. Any variances identified will be included in the morning meetings, weekly PAR meetings and QA committee.

The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent Quality Assurance Committee meeting minutes. Additionally, the Administrator, DON and/or Clinical Coordinator shall report any episodes of non-compliance with Fall Prevention process and personal alarm use recommendations/follow-up

5/30/12

identified to Quality Assurance Committee monthly for three months and then quarterly thereafter.