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

PRINTED: 08/29/2012
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
	345393	A. BUILDING ______ B. WING ______	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PISGAH MANOR HEALTH CARE CENTER	95 HOLCOMBE COVE ROAD CANDLER, NC 28715

(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 observations, record review and interviews the facility failed to implement a fall intervention for one (1) of three (3) sampled residents (Resident #36). The findings are: Resident #36 was admitted to the facility with diagnoses of fractured femur, difficulty walking, lack of coordination, abnormality of gait and dementia. A review of the Care Area Assessment (CAA) from an annual Minimum Data Set (MDS) dated 10/25/11 revealed that Resident #36 had a history of falls and that a personal alarm should be in place at all times to alert staff of unassisted attempts to rise from the bed or wheelchair. A quarterly MDS dated 7/24/12 noted that the resident had severe cognitive impairment. The MDS also revealed the resident required extensive assistance with transfers and most activities of daily living. A review of the Care Plan updated on 7/24/12 documented that Resident #36 was at risk for falls and interventions were in place which	F 323	F 323 1. 8/09/2012- Education and instruction was given to the two CNAs for the affected resident at the time of the incident. 2. A) 8/29/2012- Residents TABs alarm was replaced with a sensor pad alarm. Resident was observed removing TABs alarm by a staff member. B) 8/29/2012- Education and instruction was given in a CNA meeting for the procedure and placement of alarm devices. A memo was also distributed with minutes from the meeting for all CNAs to reinforce the procedure discussed in the meeting. The same information was posted for all nurses on their message board. C) 9/05/2012- Education and instruction was given in a nurses meeting for the procedure and placement of alarm devices. *Nurse to Nurse communication form* with alarm devices for residents was reviewed as well. 3. A) Safety alarms are fired on the PDA to each CNA and on each shift to notify staff of alarm being in place. B) *Nurse to Nurse Communication* report for each shift has listed the residents who required an alarm device.	09/05/12 PER PHONE CALL W/ ADM 09/11/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 9/7/12

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.

RECEIVED
SEP 10 2012
BY:

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F 323	Continued From page 1 included a personal alarm at all times to alert staff of unassisted attempts to rise from the bed or wheelchair. A review of the Nursing Assistant (NA) Guide located on the Care Plan and NAs personal digital assistant (PDA) noted to check that a personal alarm was in place at all times for Resident #36. A review of an incident report dated 8/1/12 revealed Resident #36 was found lying on the bathroom floor. Resident was observed to have a red/purple discoloration with slight swelling of her left knee. Resident was assessed, reported pain level at 5 out of 10, and received Tylenol for pain. The incident follow-up report revealed the resident's personal alarm was not in place at the time of the fall. Staff was re-educated to check personal alarm placement. On 8/16/12 at 9:36 AM Resident #36 was observed sitting in her wheelchair in the hallway with no personal alarm in place and unsupervised. On 8/16/12 at 9:40 AM Resident #36 was observed sitting in her wheelchair in the hallway. A staff member was observed placing a gait belt around the resident's waist, then placed a walker in front of the resident and assisted the resident to stand. No alarm sounded when Resident #36 stood up from the wheelchair, no personal alarm was observed on the resident or wheelchair and staff was observed to leave the resident with no personal alarm in place and unsupervised. On 8/16/12 at 10:14 AM Resident #36 was observed sitting in her wheelchair in the hallway. A staff member invited the resident to an activity.	F 323	C) 8/31/2012- Safety alarm check off is on the *Performance Improvement Rounds* completed weekly by the Leadership Team. The team was educated as to how to identify residents requiring the use of a safety alarm. 4. A) 9/2/2012- *Safety Alarm Check Sheet* was implemented. DON will check placement and function of alarm devices randomly weekly x 1 month, bi-weekly x 1 month, and monthly x 3 months ending January 12, 2013. B) *Performance Improvement Rounds* will be completed weekly and at random by the leadership team and turned into the Administrator. Falls committee will review the safety alarm list for the building monthly for effectiveness and use. 5. The *Safety Alarm Check Sheet* intervention and any findings from the Falls Committee review will be reported to the QA committee quarterly. The next meeting is scheduled for October 10, 2012. If problematic areas occur, they will be addressed at the time of the findings and brought to the attention of the QA committee.	

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F 323	Continued From page 2 A personal alarm was not in place and the staff member was observed to leave the resident with no personal alarm in place and unsupervised. On 8/16/12 at 11:11 AM Resident #36 was observed sitting in her wheelchair in her room. A personal alarm was not in place and no supervision was observed. On 8/16/12 at 1:11 PM Resident #36 was sitting in wheelchair in hallway outside of the dining room. A personal alarm was not in place and no staff supervision was observed. On 8/16/12 at 1:57 PM Resident #36 was sitting in her wheelchair in her room. A personal alarm was not in place and no supervision was observed. An interview on 8/16/12 at 2:10 PM with NA #1, Resident #36's assigned NA for the day revealed that Resident #36 had a personal alarm in place at all times. NA #1 displayed fall interventions related to Resident #36 on the PDA; personal alarm to be in place at all times was visible on the PDA. On 8/16/12 at 2:27 PM, NA #1 entered Resident #36's room and observed the resident was seated in her wheelchair with no personal alarm in place. NA #1 located a personal alarm from the head of the resident's bed and attached the alarm to the resident and her wheelchair. NA #1 stated that another NA assisted Resident #36 out of bed today. NA #1 also stated that the personal alarm should be in place at all times and didn't notice that the alarm was not in place during his shift.	F 323		

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F 323	Continued From page 3	F 323		

An interview on 8/16/12 at 2:39 PM with NA #2, the NA who assisted Resident #36 out of bed on 8/16/12, stated that she assisted NA #1 with his assigned residents due to an extremely busy day. NA #1 stated that she was aware the resident was to have a personal alarm in place at all times and did not remember putting a personal alarm on the resident nor did she think about the personal alarm.

An interview on 8/16/12 at 2:44 PM with Licensed Nurse (LN) #1, Resident #36's assigned nurse for the day, revealed that the resident should have a personal alarm on at all times. LN #1 stated that she was not aware the personal alarm was not in place on 8/16/12 and expected the NA staff to have the personal alarm on Resident #36 at all times.

On 8/16/12 at 3:41 PM the Director of Nursing (DON) was interviewed. The DON stated that interventions to prevent falls should be in place at all times. A resident that required a personal alarm at all times would have an alarm for the bed and the wheelchair. The DON stated that she would expect Resident #36 to have a personal alarm on at all times as an intervention to prevent falls as specified in the plan of care.