STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING ________ B. WING ________	C 09/04/2012

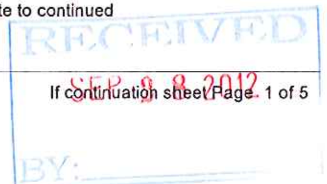
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HWY 801 SOUTH ADVANCE, NC 27006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement fall precautions for a resident who fell and broke her wrist and sustained a head injury for one (1) of three (3) sampled Residents (Resident #2). The findings are: Resident #2 was re-admitted to the facility on 3/22/12 with diagnoses that included advanced dementia, history of falls, and a hip fracture among others. Review of Resident #2's care plan for falls updated on 4/13/12 and on 6/8/12 revealed the resident was at an increased risk for having a fall related injury and specified the resident fell on 4/13/12, 4/15/12, 4/16/12 and 6/8/12. The care plan's interventions for the resident specified she was to be supervised and monitored closely at all times. The most recent quarterly Minimum Data Set (MDS) dated 7/12/12 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	9/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Sexton
TITLE: Administrator
(X6) DATE: 9/27/12

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.

original signature 9-25-12
mh



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F 323	Continued From page 1 (ADLs), was not steady walking or moving from a seated to standing position, ambulated with assistance and had fallen two or more times with injury. Review of Resident #2's medical record revealed a nurses' entry dated 6/8/12 that specified the resident was sent to the Emergency Department for evaluation after she fell and sustained a laceration to her forehead and complained of right hand pain. The Emergency Department discharge report dated 6/8/12 was reviewed and revealed Resident #2 had a right distal radius fracture and laceration to the face that required sutures. A document titled "Resident Incident Report" dated 6/8/12 was reviewed and specified Resident #2 stood up unassisted from her wheelchair, walked two steps and fell striking her head on a hand rail. On 9/4/12 at 2:30 p.m. Resident #2 was observed in her wheelchair participating in a group activity. After the activity a staff member assisted the resident to the nurses' station. During this observation licensed nurse (LN) #1 was interviewed and stated that Resident #2 was kept at the nurses' station for close supervision and monitoring. She added that the resident would attempt to get up unassisted and was at risk for falls. On 9/4/12 at 3:30 p.m. nurse aide (NA) #1 was interviewed. NA #1 stated that she worked the 3 p.m. to 11 p.m. shift on 6/8/12, but was not assigned to care for Resident #2. NA #1 reported on 6/8/12 at 5:15 p.m. she was half way down the	F 323	F323 A. Corrective action for resident #2: The fall care plan for resident #2 has been reviewed and appropriate falls interventions are in place. Resident #2 was placed on 1:1 supervision and was observed for safety and attempts to stand. During a 48 hour monitoring period Resident #2 was able to remain safely seated as assessed by the Quality Assurance (QA) Committee and the following interventions remain in place: chair alarm, bed alarm, Broda chair, bed in lowest position, scoop mattress, offer frequent toileting, reeducated resident on use of call bell, insure resident is in high traffic area when up. NA # 2 was counseled and a written warning was issued on 6/12/12 on the proper procedures for reporting off to nurse and coverage prior to leaving unit. B. Identification of other residents who could be affected by this alleged deficient practice: All residents were assessed for risk of falls. (10) residents were identified as a high risk for falls and had a care plan in place and reviewed by the QA Committee to ensure that appropriate interventions were in	9/25/12

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F 323	Continued From page 2 500 Hall assisting her assigned residents and observed Resident #2 ambulating unassisted near the nurses' station. NA #1 stated Resident #2 fell before she was able to respond to the resident. NA #1 specified there were no other staff members near the nurses' station at the time of the fall. She added Resident #2 was at risk for falls and was to be observed at all times for attempts to stand. On 9/4/12 at 4:00 p.m. licensed nurse (LN) #2 was interviewed. LN #2 reported Resident #2 required close supervision because of her advanced dementia and history of falls. She added that the resident was kept near the nurses' station for close monitoring because it was a highly trafficked area. LN #2 reported that on 6/8/12 at 5:15 p.m. she was administering medications on the 400 Hall while staff were assisting residents to the dining room for the evening meal. LN #2 reported that she heard NA #1 call for help and observed Resident #2 on the floor. She added that the nurse aides assigned to Resident #2 had left the hall to go on break without reporting to her. LN #2 confirmed that Resident #2 was not being closely monitored at the time of the fall because the nurse aides left their assignments without notifying other staff. LN #2 stated that she expected nurse aides to report to her when they needed to leave their assignment, including bathroom breaks. On 9/4/12 at 4:15 p.m. NA #2 was interviewed. NA #2 reported that on 6/8/12 she shared an assignment with NA #3 on the 400 Hall which included ensuring the Resident #2 was properly supervised. NA #2 stated that on 6/8/12 at 5:15 p.m. she left the hall to go to the bathroom	F 323	place for these residents. C. Systemic Changes: All staff including nurses, C.N.A.'s, dietary, housekeeping, and therapy were in-serviced 9/7/12 - 9/14/12 by the Staff Development Coordinator on falls prevention, falls protocols, and accident prevention and management and reporting off when leaving unit. Nurses were educated on the procedures for implementing 1:1 monitoring as a falls preventative safety intervention and the responsibility of the nurses to implement appropriate interventions including monitoring 1:1 as warranted and notifying the D.O.N who will evaluate the effectiveness of the monitoring plan and report outcomes to the QA Committee. When appropriate, 1:1 monitoring for the resident will be implemented by the nurse in charge or nurse Unit Director and observations will be recorded on the 1:1 Monitoring Tool by the monitoring staff members until the Nurse Unit Director and QA Committee evaluate the effectiveness of the monitoring and need for further interventions.	

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F 323	Continued From page 3 without notifying her licensed nurse (LN #2). She added that NA #3 was also on break at this time and that while she was in the bathroom no one had been asked to monitor Resident #2. She reported that while she was in the bathroom Resident #2 fell and sustained an injury. She stated that she was not aware she needed to report to someone when she left the hall to go to the bathroom. On 9/4/12 at 5:00 p.m. the Director of Nursing (DON) was interviewed and stated she would expect the nurse aides to report to the licensed nurse as well as another nurse aide before leaving their assignments to ensure the residents were being monitored. The DON also reported that Resident #2 was very much at risk for falls because of her advanced dementia. She added that Resident #2 had required one on one supervision but currently only needed close supervision that meant she was to be monitored at all times. The DON explained that close supervision meant that the resident was not left unattended for long periods because of her risk for falling. She stated that to monitor the resident, she was kept active by attending group activities and was also kept close to the nurses' station most days. The DON also stated the licensed nurses would at times keep Resident #2 near their medication carts to monitor her attempts to stand unassisted. The DON was aware that the nurse aide assigned to care for Resident #2 on 6/8/12 left the hall without notifying another staff member and would have expected her to notify the licensed nurse and the other nurse aide assigned to the 400 Hall. On 9/7/12 at 8:00 a.m. a telephone interview was	F 323	This information has been integrated into the standard orientation training for new hires. Residents are assessed for risk of falls on admission, quarterly and with a significant change of condition. Residents who are identified as high risk for falls are integrated into the fall prevention program for walking, strengthening, exercise, and activities to help prevent boredom, agitation, and to help increase safety awareness and optimal physical functioning. High risk residents are maintained for two weeks in the program and goals and progress are recorded on the Falls Prevention and Functional Maintenance Program form by the C.N.A. then reevaluated by the D.O.N/designee who will report to the QA Committee on the effectiveness of each individual plan and the need for further interventions. D. Monitoring to Ensure Compliance: Falls are reviewed Monday through Friday by the QA Committee and appropriate interventions are implemented, care planned, and communicated	

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F 323	Continued From page 4 conducted with NA #3. During this interview NA #3 stated she was assigned to care for Resident #2 on 6/8/12. She stated that Resident #2 had to be carefully watched because of her fall risk status and frequent attempts to stand unassisted. She stated that "carefully watched" meant that someone was watching the resident at all times. She added that unless the resident was in bed she was not to be left alone. The NA reported that she would place Resident #2 in her wheelchair at the nurses' station so someone at the desk could monitor the resident closely. She stated that she was trained to report to the other nurse aide assigned to the hall and her licensed nurse that she was going on break to ensure that her residents would be monitored. She stated that on 6/8/12 at 5:00 p.m. she left Resident #2 at the nurses' station and left the hall to go on break. She added she could not remember if there were other staff members at the nurses' station when she left the resident. She stated that she thought she notified NA #2 but did not report to LN #2 that she was leaving the hall to go on break. She stated that she left Resident #2 at the nurses' station along with other residents who were being assisted to the dining room for the evening meal and added she assumed another nurse aide would assist Resident #2 to the dining room. NA #3 reported that Resident #2 did not get assisted to the dining room and was left alone at the nurses' station at the time of the fall. NA#3 stated she was gone five (5) minutes when she was notified the resident had fallen.	F 323	to the Nursing Assistants through the Smart Charting computer program. New admissions will be reviewed for completion of a falls risk assessment and care plan developed as indicated. This will continue for four weeks then weekly for three months. The QA Team will assure residents' environment remains as free of hazards as possible and residents receive adequate supervision and assistive devices to prevent accidents. The QA Committee will monitor weekly for adjustments as necessary to assure effectiveness and on-going compliance. Any identified issues will be reported to the Administrator. E.Completion date: 9/25/12	