STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 interviews and record review, the facility failed to put the hand rest down on the bath/shower chair or utilize a safety belt to prevent a fall for 1 (resident #1) of 3 residents reviewed for falls. Findings included: A review of the ARJO bath/shower manufacturer instructions dated April 2000 indicated the hand rest of the chair should be lower when a resident is in the chair and that a safety belt should be secured around the residents' waist for safety. Resident #1 was admitted to the facility on 11/20/13 with orders for comfort measures. Cumulative diagnoses included a fall with resulting intraparenchymal hemorrhage (bleeding inside the brain). The most recent Minimum Data Set stated 1/29/14 was a 30 day assessment which indicated resident #1 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). Resident #1's care plan dated 11/20/13 included fall interventions to include keeping the bed in the lowest position, keeping the call bell in reach, an alarm pad to the bed and hourly monitoring.	F 323	F323 On 12/24/2013 NA#1 was in-serviced by the SDC Nurse on the safe and proper use of the ARJO bath/shower chair. On 2/13/2014 All ARJO shower/bath chair lifts were removed from the building until all nursing staff could be in-serviced on their proper functioning and use of safety devices. Beginning on 2/18/2014, all nursing staff, including Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA), will be in-serviced on the ARJO shower/bath chair lift. The in-service includes an instructional video on the proper use and function, and what safety measures should be followed when using the ARJO shower/bath chair lift. Beginning on 2/18/2014 all nursing staff, including RN□s, LPN□s, and CNA□s will complete a skills check list. Each nursing	3/4/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/21/2014

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F 323	Continued From page 1 A review of the incident report dated 12/19/13 indicated resident #1 had a witnessed fall at 3:15 AM. The report read that the nurse heard the alarm pad sounding and observed resident #1 standing in his doorway. She went to assist resident #1 when he began ambulating up the hallway and slipped and fell landing on his buttocks. He hit his head on the edge of the doorway of another resident's room. A 3.0 centimeter laceration was noted to the right side of resident #1's head above and behind the right ear. The nurse noted no stitches were indicated and resident #1 was assessed for additional injuries. The physician was notified and neurological checks were started along with hourly monitoring. A review of the neurological assessment indicated neurological status remained at resident #1's baseline. The responsible party (RP) was notified at 8:37 AM and insisted resident #1 be sent to the emergency room for further evaluation. The physician was contacted and orders were given to send resident #1 out to the hospital. The involved nurse was unavailable for interview. In another incident report dated 12/19/13 and timed as 8:30 AM, resident #1 was up in the shower room with the assigned nursing assistant #1 (NA) preparing to go to the hospital for evaluation from the fall earlier on 11-7 shift. Resident #1 was sitting on the bath/shower chair when the NA #1 reached to adjust the water temperature. Resident #1 leaned forward and fell to the floor again striking his head on the floor. The assigned nurse assessed resident #1 and there was no new injures noted and his neurological status remained at his baseline. This nurse was also unavailable for interview. The physician and RP were notified of the second fall	F 323	staff employee will physically demonstrate to either the DON, ADON, and or SDC Nurse how to properly position a resident in the ARJO bath/shower chair, appropriately fasten the seat belt, position the arm rest (arm bars) correctly when in use, and lock/unlock the brakes. Beginning on 2/18/2014 all nursing staff, including RN□s, LPN□s, and CNA□s will complete a comprehensive quiz on the proper and safe use of the ARJO bath/shower chair. Beginning 2/24/2014 the ARJO bath/shower chair in-service, including the instructional video, skill demonstration checklist, and quiz will be given to all new hires at the time of orientation by the SDC Nurse and/or ADON. The Director of Nursing, Assistant Director of Nursing ,and/or the SDC Nurse will audit once weekly for three months and monthly thereafter baths given in the ARJO bath/shower chair to ensure that proper use and safety measures are followed, including the proper use of arm rests and seat belts. The results of the monitoring will be reported to the facility□s quarterly Quality Assurance (QA) Committee. The QA Committee will determine the need and frequency of further monitoring. The Administrator and or Assistant Administrator will inspect once weekly for three months and monthly thereafter, all	

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F 323	Continued From page 2 occurring at 8:30 AM. A review of the hospital records dated 12/19/13 indicated there was a small laceration measuring 1cm to the right parietal area that appeared healed. The computed tomography scan of resident #1's head revealed a large left frontal intraparencymal hemorrhage with a change in the focus area from previous hemorrhage on 11/1/13. Also noted was a slight fracture of the left clavicle. There were no new orders and resident #1 returned to the facility on 12/20/13 with continuation of comfort measures. In an observation on 2/11/14 at 8:30 AM, the ARJO bath/shower chair was observed in the 700 hall shower room. The bath/shower was not in use. The hand rest were observed in the up position and there was no observed safety belt on the seat of the chair. In an interview on 2/11/14 at 10:00 AM, the NA#1 involved in the fall that occurred in the shower room stated she took resident #1 to shower off the cream that was on the resident prior to him going out to the hospital. She stated the nurse told her the medication in the Elimite cream (used to treat rashes and suspected scabies) had to be washed off so she was going to put resident #1 in the tub rather than the shower. The NA #1 stated she did not lower the hand rest on the bath/shower chair to prevent resident #1 from falling from the shower chair. She stated she could not recall being told about the need to lower the hand rest on the chair for resident safety and was not aware that a safety belt was on the bath/shower chair. The NA #1 stated after the fall, she was individually in-serviced on the use of the bath/shower chair by the staff development	F 323	three of the W.R. Winslow□s ARJO bath/shower chairs to ensure the proper function of the arm rests (arm bars), brakes, and seat belts. The results of the monitoring will be reported to the facility□s quarterly Quality Assurance (QA) Committee. The QA Committee will determine the need and frequency of further monitoring.	

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F 323	Continued From page 3	F 323		

coordinator (SDC).

In an interview on 2/11/14 at 10:15 AM, the director of nursing (DON) recalled the SDC met with the NA #1 and showed her how to use the bath/shower chair. The DON stated all staff including the involved NA #1 was oriented to the use of the bath/ shower chair on hire. The DON stated no counseling was done regarding this incident and this was the first incident involving this NA #1.

In an interview on 2/11/14 at 10:27 AM, the SDC stated she was informed of the fall then she, the DON and the NA #1 restaged the incident involving resident #1. The SDC stated she did individual in-servicing with the NA #1 on the proper use of the bath/shower chair and the reeducation on putting the hand rest down and not leaving a resident unattended in the bath/shower chair. The SDC was unaware if the bath/shower chair had a safety belt.

In an interview on 2/11/14 at 11:15 AM, NA #2 recalled she always worked with resident #1 but she was off the day he fell. NA #2 stated resident #1 did not exhibit and changes in his mental status or functional changes after the fall. She stated resident #1 was a feeder and she assisted him with his meals. She stated no change in his range of motion in his upper extremities after the fall. She recalled the RP brought in a sling for resident #1 to wear, but he would not keep it on and the physician never ordered it.

In an interview on 2/11/14 at 11:25 AM, nurse #2 stated she worked with resident #1 after the previous first shift nurse left. She recalled no changes in his mental status after the fall. The

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F 323	Continued From page 4 nurse #2 stated there was no sling prescribed for resident #1.	F 323		