STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345550	A. BUILDING ______ B. WING ______	C 02/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK OF WAXHAW	700 HOWIE MINE ROAD WAXHAW, NC 28173

(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 reviews and staff interviews the facility failed to provide supervision and place a sensor pad alarm in a wheelchair to alert staff of unsafe transfers for a resident who had a fall with injury in 1 of 3 residents with a history of falls. (Resident #1). The findings included: Resident #1 was admitted to facility on 12/21/12 with heart disease, osteoarthritis, osteoporosis, dementia, anxiety and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 12/03/13 indicated Resident #1 had no short term or long term memory problems and was cognitively intact for daily decision making. The MDS also indicated Resident #1 required limited assistance with 1 person physical assistance with transfers and had impairment in her upper extremities on 1 side. A review of a physician's order dated 01/24/13 indicated alarm to bed/chair to alert staff of unsafe transfers due to unsafe transfers related to decreased safety awareness with history of falls secondary to anxiety.	F 323	White Oak of Waxhaw ensures the resident environment remains as free of accident hazards as possible; and that each resident receives adequate supervision and assistive devices to prevent accidents. Resident #1 no longer resides at White Oak Waxhaw. The staff (Nurses, Nursing Assistants,Social Service staff, Activity staff,& Administrative staff) will be re-educated on placement of and monitoring the placement of alarms to reduce the risk of resident falls. This re-education will be completed by the Staff Development Coordinator(SDC) or Assistant Director of Nursing(ADON) and completed prior to 3/13/2014. Newly hired staff receive this education during their specific job orientation. An audit has been completed on residents who have alarms as assistive devices to ensure devices are communicated to the	3/17/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/07/2014

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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A review of a care plan titled fall risk indicated Resident #1 had a history of falling and was at risk for further falls and fractures related to osteoporosis, poor safety awareness and desire for independence. The goal indicated Resident #1 would not have any falls through the next review date of 03/06/14 and the approaches indicated in part to monitor for changes in condition that may warrant increased supervision/assistance and notify the physician; keep call bell within reach and instruct to use it for assistance; keep environment well lit and clutter free; keep personal items within easy reach; monitor for unsafe acts and redirect as needed for safety; monitor for placement of bed/chair alarms.

A review of nurses notes dated 01/23/14 at 1:51 PM indicated Nurse #1 was called into Resident #1's room by Nurse Aide (NA) #1 at approximately 9:00 AM and Resident #1 was observed lying face up on the floor next to wheelchair. The notes further indicated Resident #1 was alert and verbal but was complaining of pain in her right hip. The notes revealed a Physician's Assistant (PA) was in the building and assessed Resident #1 and ordered for her to be transported to the emergency room for evaluation.

A review of a physician's order dated 01/23/14 indicated to send Resident #1 to the hospital for evaluation of right hip.

A review of a facility occurrence report dated 01/23/14 indicated NA #1 called Nurse #1 into Resident #1's room at approximately 9:00 AM and the resident was noted lying on floor face up

staff utilizing the electronic care guide. This audit will be completed by 3/13/2014 by the Corporate Nurse Consultant.

The Restorative Nurse will monitor new device orders and changes in device orders on an ongoing basis. The Restorative Nurse will continue to update the electronic care guide as needed.

The Nurse Administration(including Nurse Supervisors, Director of Nursing (DON), ADON,SDC, Restorative Nurse and Treatment Nurse) are completing a round check sheet to monitor placement of alarms for those residents with physician orders for alarms each shift times 4 weeks, then periodically thereafter.

The DON, ADON,SDC or Restorative Nurse will review the alarm round check sheets daily(Monday-Friday)for 4 weeks,then monthly to identify any re-education or disciplinary needs.

The Restorative Nurse, Nursing Adminstration and Administrator will continue to investigate occurrence of resident falls daily(Monday-Friday) to ensure ongoing compliance to F323.

Identified trends from the audit and

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F 323	Continued From page 2 next to a wheelchair. The report indicated Resident #1 was alert and responded to touch, voice and painful stimuli and had pain that was severe in intensity in her right hip. The report also indicated Resident #1's fall was unwitnessed and she was found on the floor face up and her wheelchair was nearby. The report revealed Resident #1 had a wheelchair as an assistive device and an alarm sensor as a protective physical device. A hand written statement dated 01/23/14 by NA #2 indicated she walked into Resident #1's room on 01/23/14 and Resident #1 had got up by herself and was seated in her wheelchair at the closet getting clothes. The statement indicated she asked Resident #1 if she needed anything and she said no because she could do it on her own and the next time she walked in Resident #1's room she had slid out of the wheelchair on the floor. A hand written statement dated 01/23/14 by NA #1 indicated when breakfast was being served on 01/23/14 she was taking vital signs on a resident when she noticed the door of Resident #1's room was closed. She stated she stopped doing the vital signs and went to open Resident #1's door and when she did she saw Resident #1 lying on the floor. She stated she reported to the nurse immediately and took the Resident #1's vital signs and stayed with Resident #1 until emergency medical services arrived. A review of a hospital discharge summary dated 01/24/14 indicated Resident #1 was admitted to the hospital on 01/23/14 with a fracture of right hip with no plan for surgery because of advanced heart disease.	F 323	rounds are discussed during the morning Quality Improvement(QI)meeting (Monday-Friday) with recommendations for system changes as needed times 4 weeks,then monthly thereafter. The trends are also discussed in the quarterly QI meetings for recommendations. The DON and or Administrator are responsible for ongoing compliance to F323. Compliance date is 3/17/2014	

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F 323	Continued From page 3 A review of physician's orders dated 01/24/14 indicated to re-admit to the facility and resume all previous medications, treatments and ancillary orders including an order for a bed/chair alarm and Hospice consult due to non-operable right hip fracture. During an interview on 02/17/14 at 11:55 AM Nurse #1 explained Resident #1 was very alert and independent and wanted to do everything for herself. She stated Resident #1 was at risk for falls and had a bed/chair alarm and a motion sensor at her bathroom door. She explained Resident #1 would transport herself in her wheelchair to the bathroom and the motion sensor alarm would sound to alert staff to assist her. She stated on the morning of 01/23/14 she noticed the door to Resident #1's room was closed but that was odd because the door was always left open so staff could keep a close eye on her since she was a fall risk. She further stated NA #1 went into Resident #1's room and then called her into the room. She explained when she went in the room she saw Resident #1 lying face up on the floor of her room and was complaining of pain in her right hip. She stated it looked like Resident #1 might have been trying to get something out of her dresser. Nurse #1 explained Resident #1 had a sensor pad alarm on her bed that was supposed to be placed in her wheelchair when staff got her out of bed but on 01/23/14 the sensor pad alarm was not in place in her wheelchair and there was no alarm sounding when they found Resident #1 lying in the floor. She further explained NA #2 who no longer worked at the facility had been assigned to Resident #1's care on 01/23/14 but did not usually work on that hall and did not put the alarm	F 323		

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F 323	Continued From page 4 in Resident #1's chair when Resident #1 got up that morning. During an interview on 02/17/14 at 12:48 PM with NA #1 she stated Resident #1 was independent and wanted to do things for herself. She explained she was at the nurses station on the morning of 01/23/14 and noticed Resident #1's door was closed and thought that was strange because Resident #1 was a fall risk and staff were supposed to supervise her and her door was not supposed to be closed. She stated Resident #1 was supposed to use her call bell for assistance but she would often stand up from her wheelchair to get clothes out of her closet or try to get things out of her dresser and would not call for assistance because she wanted to do it herself. She explained she was not assigned to Resident #1 on 01/23/14 but was assigned to other residents on her hall and went to Resident #1's room because she wanted to check on her since the door was closed. She further explained when she opened the door there were no staff in the room and Resident #1 was lying on the floor. She stated she she called for Nurse #1 and she came in the room and assessed Resident #1. She explained Nurse #1 called for the PA and Resident #1 was sent to the hospital. NA #1 stated Resident #1 was supposed to have a bed/chair alarm because Resident #1 frequently tried to transfer by herself but there was no alarm sounding when she went in Resident #1's room on 01/23/14 and found her lying in the floor. She stated Nurse Aides (NAs) had assignment sheets to indicate which residents had alarms and the type of alarm and NA #2 should have placed the sensor alarm from Resident #1's bed in her wheelchair when Resident #1 got out of bed on 01/23/14.	F 323		

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During an interview on 02/17/14 at 2:25 PM the Restorative Director indicated she was responsible for investigation of falls. She explained it was her understanding that NA #2 was assigned to care for Resident #1 on 01/23/14 but did not know Resident #1 had an alarm. She further explained the NA's have a written assignment sheet that tells them what each resident needs and any alarms they have. She stated the electronic documentation system NAs used to document care provided also had a lot of detailed information for each resident and the alarms were listed for each resident. She explained NAs were expected to check alarms when they started their shift and nurses were also supposed to check them.

During an interview on 02/17/14 at 2:39 PM the Director of Nursing explained NA #1 went into Resident #1's room because she saw the door was closed and when she opened the door Resident #1 was lying on the floor. She further explained they investigated the fall and determined that NA #2 was assigned to care for Resident #1 on 01/23/14 and did not move the alarm from Resident #1's bed to her wheelchair. She stated staff was supposed to move the sensor pad alarm from Resident #1's bed to her wheelchair because Resident #1 would stand from her wheelchair to get clothes out of her closet or dresser because she wanted to do it herself. She explained it was her expectation that nursing staff was supposed to look at their assignment sheets to see what each resident required and which residents had alarms and she expected them to do walking rounds to check alarms. She stated it was also her expectation for all nursing staff to provide supervision of

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F 323	Continued From page 6 residents who were a fall risk and ensure safety devices such as alarms were in place and turned on.	F 323		