STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345465	A. BUILDING _____ B. WING _____	C 10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYVIEW NURSING & REHAB CENTER	**3003 KENSINGTON PARK DRIVE NEW BERN, NC 28560**

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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 review, observation and staff interviews, the facility failed to follow the manufacturer's instruction for placement of a bed alarm device for a resident admitted with a fall history from home, so that staff could hear and respond to the sound for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Findings included: According to the manufacturer's directions for use for the bed alarm device titled "Direct Supply Attendant Pressure Pad" instructs one "1) Place monitor out of reach of the resident. Suitable mounting locations may include: back of headboard, back of wheelchair, wall or under the bed and 2) the weight of some cushions can reduce the effectiveness of the alarm." The hospital discharge summary dated 7/31/14 revealed Resident #1 fell at home while going to the bathroom because she became weak and fell down. A CAT (Computerized Axial Tomography) scan of the brain without contrast showed no acute abnormalities were seen. Resident #1 was admitted into the facility on	F 323	Bayview Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Bayview Nursing & Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. F323 1. During the complaint investigation on 10/22/14 the surveyor alleged that the facility failed to follow the manufacturer□s instructions for placement of a bed alarm device for resident #1 admitted with a fall	11/19/14

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

Electronically Signed | 11/06/2014

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F 323	Continued From page 1 7/31/14. Cumulative diagnoses included Rehabilitation, Metabolic Encephalopathy, General Muscle Weakness, Abnormality of Gait, Lack of Coordination, Abnormal Posture, Communication Deficit and Dementia. A review of the nurse's note dated 8/1/14 read "Bed/chair alarm placed at family's request." The 24 hour report/change of condition report dated 8/1/14 reflected a bed/chair alarm was implemented. A review of the telephone order dated 8/4/14 revealed a neurological consult for confusion and cognitive changes. The care plan (CP) completed on 8/9/14 revealed the resident was at risk for injury due to impaired thought process with interventions which in part read "Provide consistent care giver on all shifts, keep resident environment free of clutter and safety hazards, call light within reach at all times in room and bathroom." The CP further indicated Resident #1 required staff assistance with activities of daily living (ADL) with risk for further decline due to recent acute hospitalization. At risk for falls was indicated as an identified problem on 8/9/14 due to inability to perform ADLs independently secondary to a recent acute hospitalization. Approaches to prevent falls read "Assist with one staff member for all ambulation, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician." The care plan did not reflect a bed alarm device. A review of the kardex (undated) did not reflect a bed alarm device or instruction regarding its use.	F 323	history from home, so that staff could hear and respond to the sound for supervision to prevent accidents. The surveyor also noted that the care plan for resident #1 didn□t reflect a bed alarm device. Resident #1 discharged from the facility on 9/5/14 so the facility is unable to address a corrective action with the affected resident. 9/5/14 2. To ensure other residents are not affected by the same alleged deficient practice, all staff will be educated on the Pressure Pad for Direct Supply Attendant Resident Monitors Directions for Use. This education was started on 10/22/14 by the Staff Development Coordinator and was continued on 11/5/14 during an All Staff Meeting conducted by the Executive Director, Director of Nursing Services, Staff Development Coordinator and MDS Coordinator. All remaining nursing staff will be educated on the Directions for Use by November 19, 2014. If a staff member is not educated on the Directions for Use by November 19, 2014 they will be removed from the schedule until they are able to receive this education. 11/19/14 An audit will be conducted by the MDS Coordinator, Clinical Care Coordinator, Staff Development Coordinator and Director of Nursing Services to ensure all residents that are utilizing alarms as a fall intervention have a corresponding care plan. If any residents are found to have an alarm without a corresponding care plan, the resident will be evaluated by a	

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F 323	Continued From page 2 The Care Area Assessment completed 8/9/14 listed falls as an identified problem. The root cause related to previous fall history was not specifically indicated. At risk for injurious falls was listed as analysis of findings, with care plan consideration for therapy as ordered and as needed. The falls narrative note referenced the ADL note which read "Per medical records, resident requires extensive assistance, at further risk for ADL decline with therapy as ordered and as needed." The 14 day admission Minimum Data Set (MDS) completed on 8/14/14 indicated Resident #1's cognitive pattern was severely impaired. No behavior or rejection of care was indicated. Extensive assistance with bed mobility and transfers of two persons was required. Balance was indicated as not steady (only able to stabilize with staff assistance) with transition and walking. Range of motion was impaired on one side to both the upper and lower extremities. Mobility devices included a walker and wheelchair. No falls were indicated prior to or since admission. Weight was indicated as 176 pounds. A review of the neurological consult completed on 8/22/14 revealed Resident #1 was admitted into the nursing facility for rehabilitation for sub-acute care. It was further indicated the resident was evaluated for memory impairment. Further assessment indicated the resident could walk 60 feet with assistance, had never been a physical person, had fallen at home due to nocturia (excessive urination at night), getting up in the middle of the night, fatigued easily, but is better. Balance was listed as impaired, abnormal gait, very weak legs and left arm weak. The plan included rehab (walk short distances several	F 323	nurse to be sure the alarm is an appropriate intervention and the care plan will be updated. 11/19/14 Nursing staff will complete a new falls assessment on all current residents. The assessment will be reviewed by the MDS Coordinator, Director of Nursing Services or designee and care plans will be updated as indicated per the score on the falls assessment. 11/19/14 3. To ensure this deficient practice does not recur, all nursing staff will be educated on how to communicate changes that need to be put in place on the care plan. 11/19/14 All residents with alarms will also have their Kardex updated to include instructions regarding its use. 11/19/14 Nurses will sign off on proper placement and function of all resident alarms each shift on the MAR (Medication Administration Record). 11/19/14 The Director of Nursing Services or designee will conduct audits to ensure nurses are signing the MAR for proper placement and function each shift weekly for one month, monthly for 3 months and quarterly thereafter until there have been 3 consecutive quarters with no issues. 11/19/14 The MDS Coordinator or designee will review the 24 hour communication book daily M-F (5 times per week) and update	

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F 323	Continued From page 3 times daily), brace for leg and wrist drop and a revisit in one month. The resident was assessed to be deconditioning. A review of the weekly skin assessment completed on 8/2, 8/9 and 8/23/14 revealed no concerns or bruising to the head. The 30 day MDS completed on 8/26/14 indicated Resident #1 cognitive pattern was moderately impaired. No behavior or rejection of care was listed. Extensive assistance with bed mobility and transfers of one person was indicated. Balance was indicated as not steady (only able to stabilize with staff assistance). No falls were indicated prior to or since admission. Weight was indicated as 175 pounds. A review of the nurse's notes (NN) written by Nurse #1 revealed on 9/5/14 at 3:47 am "Resident alert and able to make most needs known. Assistance with ADLs (activities of daily living) and transfers, left side weakness, call light in place and alarm in place in bed (specific location not indicated)." At 8:53 am NN in part read "Had checked on resident at 5:30 am and the resident in bed with eyes closed and her door opened at that time. Went back at 6:00 am to administer her morning meds and found resident on the floor with laceration on back of head. Her bed alarm was under her pillow going off and her door was closed when I got back. I called 911, on call doctor and her family. Resident complained of her head hurting and her back hurting. Went out via stretcher via 911 at 7:00 am." A review of the nurse notes from admission to discharge revealed Resident #1 was at times confused, required redirection, left side weakness	F 323	the resident care plans as needed. 11/19/14 The Director of Nursing Services or designee will conduct audits to spot check the care plans monthly for twelve months. Five randomly selected care plans will be reviewed each month. 11/19/14 4. Outcomes of compliance with the alarm audit, and completion of new Fall Risk Assessments will be reviewed at the Quality Assurance Committee Meeting on November 21, 2014. Any discrepancies/corrections will be addressed immediately by the Director of Nursing Services or designee. The Director of Nursing Services or designee will report on the outcomes of compliance with the weekly MAR audit one time per week at the morning Interdisciplinary Stand-up Meeting for four consecutive weeks. Any discrepancies/corrections will be addressed immediately by the Director of Nursing Services or designee. Following this, the Director of Nursing Services, or appropriate designee, will bring results of compliance to the facility monthly Quality Assurance meeting for two months for review by all committee members. Discussion of compliance/non-compliance will be entered into the committee meeting minutes. The Director of Nursing Services or appropriate designee will bring the results of compliance of the monthly care plan audit to the facility monthly Quality	

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F 323	Continued From page 4 and required assistance from the facility staff with ADLs and transfers. The notes did not reflect the resident attempted to place the bed alarm under the pillow or an attempt to get out of the bed to close the door to the room unassisted. A review of Nurse #1's written statement dated 9/5/14 read "6:00 am resident was on floor with blood behind her head. Had her lay still, kept her awake and talking, called 911, physician and family. 911 came about 7:00 am by stretcher." A review of the Emergency Medical Services (EMS) narrative report dated 9/5/14 revealed a dispatch to the nursing facility, "Upon entry arrival at the facility patient was observed lying next to the bed, patient states she slid off the bed, patient has a contusion (bruise) to the back of her head, patient denies any other injury, c-collar applied (neck brace,) loaded and transported without change, (name of hospital) called and report given." A review of the hospital emergency department pre-arrival summary notes dated 9/5/14 at 7:30 am revealed Resident #1 presented to the emergency room due to a fall/head pain. Chief complaint read "Pt (patient) slid off her bed around 6 am this morning per staff at (name of nursing facility). Pt noted with small laceration and swelling to back of head. Pt complains of left elbow pain. Poor historian and unable to tell the nurse of morning events." A CT of the brain revealed "1) left side subdural hematoma (a severe acute head injury in which blood fills the brain rapidly, compressing or squeezing brain tissue) largest diameter is 15.8 millimeter. Due to underlying atrophy (degeneration) there is very little mass effect, 2) Intraventricular hemorrhage	F 323	Assurance Committee meeting monthly for twelve months for review by all committee members. Discussion of compliance/ non-compliance will be entered into the committee meeting minutes. Any non-compliance with the audits listed above will require QA committee members to review plan and develop modifications as needed. Any modification to the plan will require re-in servicing of applicable personnel by the Director of Nursing Services, Staff Development Coordinator, or appropriate designee. Any modifications to the plan will require monitoring of such revisions.	

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(bleeding in the brain) with blood noted in the posterior horn of the right lateral ventricle: impression: chronic degenerative changes. No acute findings. X-ray of left elbow revealed no radiographic evidence of acute injury. Patient was reevaluated resting comfortable no changes in signs or symptoms. She'll be transferred to (name of medical center) for continuation of care and treatment."

A review of the staff in-service completed 9/10/14 at 2:30 pm, 3:30 pm and 11:00 pm read "All staff: ensure that all residents' doors stay open when they are not receiving patient care. If a patient insists on the door being closed - care plan, falls - review of proper documentation." The in-service did not reflect education provided to the staff related to proper placement of bed alarms so that staff could hear and respond to the sound.

A review of the death certificate dated 9/22/14 read "1) Immediate cause of death: consequences of closed head injury and 2) Underlying cause: fall on 9/5/14 (date of injury), 3) Manner of death: accident."

On 10/21/14 at 3:55 pm, in an interview, the administrator revealed she had discussed with Nurse #1 on 9/5/14 related to the resident being found on the floor. The administrator indicated Nurse #1 informed her she had just checked on the resident at 5:30 am and the resident was fine. She (Nurse #1) informed her (administrator) she had suspected in previous times the resident had attempted to get up and close the door by herself prior to the incident, however she had not seen the resident actually do so. The administrator indicated further discussion with Nurse #1 revealed she did not hear the alarm sounding

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until she actually opened the resident door to administer medications at 6:00 am, and the resident was observed on the floor. The administrator stated as an intervention to prevent re-occurrence the staff was in-serviced (educated) to leave the residents door opened. The administrator stated she and the Staff Development Coordinator (SDC) completed the in-services on 9/10/14 as a result of Resident #1's fall.

On 10/22/14 at 5:40 am, in an interview, NA (Nursing Assistant) #1 accompanied by the Director of Nursing (DON) acknowledged she (NA #1) was the primary NA for Resident #1 on 9/5/14 (date of fall) from 11 pm - 7 am. She stated she last observed the resident at 4:00 am during care rounds. She added the resident would at times attempt to get out of the bed unassisted by herself and needed reminders to ring the call bell for assistance. NA #1 stated she had never observed the resident attempting to close the door or to put the bed alarm device under the pillow. NA #1 stated at times she placed the resident's bed alarm (sounding device part) out of sight of the resident so she could not see it at the top of the pillow on the bed mattress, however she did not recall placing the alarm device underneath the pillow. NA #1 stated the type of alarm was one the resident laid on. She further indicated she did not recall if she (NA #1) closed the door, as this was against facility standards. NA #1 stated she had access to the resident Kardex and verified at 6:06 am, through computer access at the nursing station, she had access to review the plan of care for the residents. NA #1 did not elaborate where she place the bed alarm on the day Resident #1 was observed on the floor, or if she had notified a licensed nurse of the

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F 323	Continued From page 7 resident attempts to get up out of bed unassisted. On 10/22/14 at 6:10 am, in an interview, Nurse #1 accompanied by the DON and administrator acknowledged the incident (fall) witness statement dated 9/5/14 was her written statement, however did not indicate the exact location she observed the bed alarm device on 9/5/14 at 3:47 am or if she noticed the placement of the alarm device at 5:30 am. Nurse #1 indicated she did not hear the bed alarm sounding until she entered the resident's room at 6:00 am to administer meds and observed the resident on the floor beside the bed and noticed the alarm was located underneath the pillow and sounding. She stated she had never observed the resident attempting to place the bed alarm underneath the pillow, trying to get out of the bed unassisted or attempt to close her door independently. Nurse #1 denied placing the bed alarm sounding device underneath the pillow. On 10/22/14 at 9:16 am, in an interview, Nurse #2 accompanied by the administrator and DON stated she (Nurse #2) was responsible for the development of residents' care plans and the MDS. She stated she was not aware the staff was using a bed alarm device as a safety intervention for Resident #1, therefore the care plan and Kardex did not reflect such an intervention or guidance to the nursing staff or nursing assistants for usage. She indicated she was aware Resident #1 was at risk for falls on admission. Nurse #2 stated she expected if the staff implemented such as intervention as a bed alarm, he or she also needed to complete an interdisciplinary form, so communication is conveyed in the standup meeting and the care plan could have been updated. Nurse #2 stated basic interventions	F 323		

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were implemented for the resident initially which did not include a bed alarm due to the resident did not score a 10 (high risk) or above for fall risk. She stated a bed alarm would not have been implemented for a fall score of 9. Nurse #2 concluded there was no facility legend for the fall assessment to be reviewed to reveal what a score of 9 would indicate; just it was not considered high risk.

On 10/22/14 at 9:34 am, in an interview, the SDC accompanied by the DON and administrator indicated she (SDC) became aware Resident #1 was at risk for falls on admission. She also stated she was aware the resident had a fall on 9/5/14, which included knowledge the bed alarm device was located under the resident's pillow and the door closed. The SDC concluded she was present in the stand-up meeting on 9/5/14, when the team discussed the fall and the events surrounding the fall, however she did not in-service licensed nurses or nursing assistants related to ensuring bed alarms were not located under residents' pillow to minimized falls or so that staff could hear and respond to the sound.

On 10/22/14 at 9:50 am, an observation was made with the DON, SDC and administrator with a similar bed alarm on the hallway (empty room) where Resident #1 resided. The bed alarm sounding device was placed under the pillow and the door to the room was shut and the sound of the alarm could be heard with a muffled sound 38 feet away with the door shut. Upon returning to the room and opening the door the sound became louder and when the SDC removed the pillow the sound became significantly louder and apparent to one.

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F 323	Continued From page 9 On 10/22/14 at 12:00 pm, in an interview, the DON accompanied by the administrator stated she (DON) expected the bed alarm to have been placed according to the manufacturer's instructions so the alarm device could reach its full capacity when alarming and in-services for licensed nurses and nursing assistants to have been initiated on 9/5/14 (date of the fall), and the resident's care plan to reflect a bed alarm prior to the fall due to the resident was assessed at risk for falls on admission. The administrator added the 24 hour report/change in condition report is brought to each morning stand up meeting for discussion and Nurse #2 was present in the meeting held on 8/1/14.	F 323		