STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345314	A. BUILDING _____ B. WING _____	C 02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FOREST CITY	830 BETHANY CHURCH RD FOREST CITY, NC 28043

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews the facility failed to indentify and assess the need to stabilize a resident's neck and back before transfer after an unobserved fall, for one (1) of three (3) residents reviewed for accidents (Resident #2). The findings included: Resident #2 was admitted to the facility on 10/29/11 with diagnoses that included heart failure, diabetes, left sided paralysis, prostate cancer, stroke, muscle weakness, and leukemia. Review of the quarterly Minimum Data Set (MDS) dated 12/17/13 revealed the resident was cognitively intact and able to make the staff aware of his needs. Resident #2 required extensive assistance for most of his Activities of Daily Living (ADL's) to include transfers with one to two persons to assist. He was also revealed to have upper and lower extremity impairment on one side and used an electric wheelchair. Review of Resident #2's care plan that was in effect from 10/01/13 to 12/31/13 indicated he was at a risk for falls, used a power wheelchair, and	F 309	**This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **Tag F 309: It is the policy of this facility to provide adequate care and services so each resident attains and maintains, the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care. It is the policy of this facility to perform orientation and skill check off for all newly hired nurses. Further, annual skill check off is performed by each licensed nurse.** **Resident #2 was sent to the hospital for evaluation and did not return to the facility 12/30/13. Each licensed nurse was immediately retrained in assessing residents post fall for injury with focus not to move the resident when significant injury is suspected.** **For residents with the potential to be affected:** **Because all residents who require assistance with mobility, have advanced age, co-morbid disease process, poly pharmacy, and reside in a skill nursing facility are at risk for falls with injury, the Director of nurses began re-educating Licensed nurses 02/07/2014 for response to falls and moving residents post fall with suspected head and neck injuries/involvement.**	**02/22/2014**

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

Regina Walker — LPNA — 2/25/14

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.

DHSR Mail Room Received Feb 26 2014 by: PAM

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F 309	Continued From page 1 required staff assistance for transfers using a mechanical lift. Review of the nurse's notes revealed Resident #2 had two falls from his wheelchair on 12/30/13. The first fall occurred at approximately 12:50 PM when he was bending over to plug in his wheelchair to an electrical outlet and slid to the floor. Resident #2 was assessed by the nursing staff. He denied hitting his head and voiced no complaints. The record indicated he had a skin tear to the fourth finger on his right hand and was treated by staff. He was then lifted by mechanical lift back into his chair. Further review of the medical record indicated Resident #2 had a second fall from his wheelchair on 12/30/13 at approximately 2:00PM. The second fall resulted in Resident #2 being found by staff lying in floor face down, with his left arm underneath him. Resident #2 was assessed by the staff and found to have large raised area to his left forehead and a skin tear along the bridge of his nose. He was complaining of back pain and pain to his head and denied loss of consciousness. He was assessed by Nurse #1 and Nurse #2, and it was determined he would be transferred to the local Emergency Room (ER) for further evaluation. Resident #2 was then removed from his lying position in floor, placed in a mechanical lift, and put into his bed to await Emergency Medical Service (EMS) transfer to the ER. Review of ER records from 12/30/13 after Resident #2 was transferred to the hospital revealed he received a large hematoma to his head, a laceration and skin tears to his face. An x-ray of his spine revealed multiple acute cervical	F 309	**Specific measures/systemic changes to prevent reoccurrence: The director of nurses retrained licensed nurses for response to falls with suspected head and neck injuries. Further the Director of nurses and the assistant director of nurses will audit 100% of falls weekly to monitor unnecessary movement post fall. Identified concerns are immediately reviewed with the nurse or other staff involved. Each nurse is re-trained annually and skills check off are documented for each nurse to better ensure professional standard of practice and compliance for delivery of and follow through of care to residents.** **Effective 02/07/2014: All completed fall audits are reviewed in the weekly at risk meeting currently in place for other systems reviews. This is an ongoing practice and it is an addition to enhance the existing quality assurance program.** **The Director of Nursing is responsible for monitoring of compliance via review of all weekly fall reports and documentation and will report findings to the quality assurance committee quarterly.**	**02/22/2014**

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F 309	Continued From page 2 fractures to his neck. Medical records revealed Resident #2 had no loss of consciousness during his fall; and no tingling, numbness, or loss of movement in his extremities. No further neurological deficits were indicated. He did complain of a headache and pain in his back. On 02/05/14 at 1:30 PM an interview was conducted with Nurse Aide #1 (NA#1). She stated when Resident #2 had his second fall on 12/30/13; she was leaving the room of another resident and heard him call for help. She indicated he was lying face down in front of the sink. NA#1 revealed she called for the assistance of the nurse, and Nurse #1 and Nurse #2 both responded to the room. She revealed she could see Resident #2 was bleeding from a knot on his head. NA#1 stated the nurses asked Resident #2 if he was alright and he responded his back was hurting. She stated he was rolled over onto his back and he continued to complain of back pain. NA#1 indicated Resident #2 was assessed by the nurses, including his level of consciousness and vital signs. She revealed the NA's were then asked by Nurse#1 and Nurse #2 to get Resident #2 up with the lift and place him in the bed. NA#1 revealed he was lifted in a sitting position by the mechanical lift, as he continued to complain of back pain. NA #1 stated, "I was not comfortable moving him at the time because he was complaining of his back hurting." On 02/05/14 at 3:00 PM an interview was conducted with NA#2. She indicated she entered Resident #2's room after Nurse #1 and Nurse #2 were already taking care of him. She stated when she entered the room Resident #2 was on his back and she was able to observe the knot on his head and could see he was bleeding. NA#2	F 309		

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F 309	Continued From page 3	F 309		

revealed Resident #2 was complaining of pain in his back and head, but he said his back hurt worst. She indicated she left the room to get a sling for the lift and when she returned, another sling had been located and Resident #2 had been lifted and placed in bed.

On 02/05/14 at 2:40 PM an interview was conducted with Nurse #2. She indicated she entered Resident #2's room after NA#1 called for help, and before Nurse #1. She revealed he was lying face down on the floor and she could see he was bleeding from his head. Nurse #2 stated Resident #2 complained of head pain. She acknowledged he was assessed for his level of consciousness, rolled to his back, and further assessed. A decision was made to transfer Resident #2 to the ER for further evaluation. Nurse #2 stated both she and Nurse #1 made the decision to transfer resident to the bed by a mechanical lift because he was asking to be moved. She stated she was not in the room when he was transferred to the bed. Nurse #1 was unavailable for interview during the course of the investigation.

On 02/06/14 at 10:10 AM an interview was conducted with the Director of Nursing (DON). She indicated the facility has a policy for all falls, observed and unobserved, that a nurse is to assess the resident and if a head injury is involved the resident is automatically sent to the ER for evaluation. When the DON was asked about moving a resident who had suffered a head, neck or back injury from a fall; she acknowledged that during the fall investigation for Resident #2, they had identified his transfer to the bed with the use of a mechanical lift following his fall as an issue due to the nature of his injuries.

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F 309	Continued From page 4 She further indicated that the movement of a resident should be determined by individual circumstances based on their injury. The DON revealed she would have been hesitant to move Resident #2, even though he was asking to be moved. She stated, "Based on his injury, he should not have been moved". On 02/06/14 at 1:55 PM and interview was conducted with the Administrator. She stated an investigation was initiated after Resident #2's falls. She stated staff was re-educated and interventions were put into place. The Administrator acknowledged that moving Resident #2 after his second fall and before EMS arrived was not the best practice.	F 309		