

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345191 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/16/2017 |
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| NAME OF PROVIDER OR SUPPLIER SURRY COMMUNITY HEALTH AND REHAB CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 | | |
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| F 323 SS=G | <p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, physician and staff interviews and record review, the facility failed to call for additional assistance, provide interventions for a resident with combativeness during care, and prevent an injury while providing care when Resident # 1 was agitated, moving about in bed and struck her head on the side portion of the metal side rail. Resident #1 was sent to the hospital after a change in condition was noted. A diagnosis of a subdural hematoma</p> | F 323 | <p>1. Resident care specialist notified nurse of resident's head being bumped over side rail during incontinence care. Assessment completed and neuro checks initiated. Upon change of condition, MD notified and resident sent to emergency department.</p> <p>2. AD HOC QAPI completed on Friday, 03/10/17 to ensure procedures in place to</p> | 4/13/17 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/07/2017

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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| F 323 | <p>Continued From page 1</p> <p>(brain bleed) and a hematoma was made at the hospital. This was one resident in a sample of three with accidents.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 4/14/16 with a diagnosis including dementia.</p> <p>Review of the Annual Minimum Data Set (MDS) dated 2/23/17 indicated Resident #1 had long and short term memory problems with moderate impairment for decision making skills. The assessment indicated the resident did not exhibit any behaviors. This MDS indicated she required extensive assistance of 2 or more persons for bed mobility, and one person extensive assistance for personal hygiene and toileting. The MDS indicated she was non-ambulatory and was totally incontinent of bowel and bladder. There were no falls during the assessment timeframe and she was receiving hospice services.</p> <p>Review of the care plan, last updated 2/24/17, revealed a potential for skin tear related to fragile skin and history of skin tears. The interventions included pad the bed rails, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. The care plan indicated the resident was incontinent of bowel and bladder. The interventions included to check residents every two hours and to provide incontinence care. The care plan did not indicate how many staff were needed to provide incontinence care and did not address behaviors of agitation.</p> <p>The monthly recap orders for February and</p> | F 323 | <p>prevent this type of incident from happening again. Facility audit completed for the past 30 days and no similar events were found. Staff was immediately re-educated to lower side rails completely if resident is unable to use for turning and positioning during incontinence care, as well as to consider extra measures such as getting extra help if resident is confused, agitated, or uncooperative. Side rail assessment will be completed for 100% of residents by 3/14/17.</p> <p>3. All staff will be educated on proper methods of turning and positioning and side rail adjustment via demonstration and return demonstration, as well as to consider extra measures such as getting extra help if resident is confused, agitated, or uncooperative by 3/10/17. After 3/13/17 staff will not be allowed to work until training is completed. Director of Nursing or Assistant Director of Nursing will complete audits for 12 residents weekly for four weeks and monthly for three months to ensure compliance. Additional education provided to staff on Resident Combativeness, Contributing Factors, and Prevention/De-escalation on 04/06/17 and will be completed by 4/13/17.</p> <p>4. All weekly audit results and findings will be brought to QAPI meeting monthly for 3 months or until no further issues are noted. The plan will be adjusted as needed based on results in order to ensure effectiveness.</p> | | |

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| F 323 | <p>Continued From page 2</p> <p>March included an order for an antianxiety medication to be administered as needed. Review of the Medication Administration Record revealed the medication had not been administered.</p> <p>Review of the documentation by the nursing assistants (NA) for the dates of 2/28/17, 3/1/17, 3/2/17, 3/4/17, 3/5/17, 3/7/17 3/8/17, and 3/9/17 indicated Resident #1 needed total assistance with bed mobility provided by one person 14 times and needed total assistance with bed mobility by two persons 10 times. The documentation indicated two staff provided care during the second shift (3:00 PM to 11:00 PM).</p> <p>Review of the nurse ' s note dated 3/10/17 at 1:45 PM revealed Resident #1 had "hit her head over the bed rail. She has a knot, it is red and blue bruise." The note revealed her nose started bleeding. She was sent to the hospital to be evaluated. It (incident) happened around 10:30 AM but did not swell up (knot on her forehead) until around 12 noon. Neurological checks were done, and were within normal limits up to the time she went to the hospital. Emergency Medical Services (EMS) were called at 12:35 PM and she left the facility at 12:55 PM. On 3/10/17 she was alert the entire time and did say her head hurt.</p> <p>Review of the "Incident/Accident Report" dated 3/10/17 described the findings of the incident as the NA rolled Resident #1 to change her (incontinent brief) and she hit her head over the bed rail. There was a large knot over the left eye, bruise and nose bleeding.</p> <p>Review of a "SBAR Summary" (communication form to the physician) dated 3/10/17 at 1:25 PM</p> | F 323 | | | |

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| F 323 | <p>Continued From page 3</p> <p>revealed Resident #1 ' s vital signs were obtained with a blood pressure of 118/64, pulse 62 and regular, respirations were 20 and oxygen saturation was 92%. The physician was notified she had a knot over her left eye, with bruising and redness. Her nose started to bleed a small amount. The neurological checks were within normal limits when she left for the hospital for evaluation.</p> <p>Review of the hospital admission history and physical dated 3/10/17 revealed Resident #1 had suffered a traumatic subdural hematoma. The resident was found to have a superficial hematoma after some time and was taken to the emergency room where she was found to have a small right parietal acute subdural hematoma, in addition to her scalp hematoma. The resident was alert, awake but slow to answer questions. She was oriented to person.</p> <p>An interview was conducted on 3/15/17 at 11:55 AM with NA#1, who provided incontinence care on 3/10/17 and during which time the resident hit her head on the side rail. The NA revealed she was familiar with Resident #1 and had taken care of this resident by herself at times. NA#1 explained Resident #1 was hard to provide care for at times and that Friday (3/10/17) was "the worst day." She further explained she was trying to work with her by herself. During the incontinence care Resident #1 was "scooting and scooting towards me." NA#1 explained the resident had a bowel movement and it was on her hands. When she tried to clean her hands, Resident #1 became agitated. NA#1 explained the resident was moving her arms and legs and scooted closer to her and down in the bed. Further interview revealed NA#1 was cleaning the</p> | F 323 | | | |

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| F 323 | <p>Continued From page 4</p> <p>resident with one hand and trying to hold her onto her side with the other hand. NA#1 explained during incontinence care she had turned Resident #1 towards her, attempted to pull the brief out from under her with one hand and hold her with the other hand. Resident #1 hit her head on the side rail when she scooted down in bed and scooted closer to NA#1. Resident #1 hit her forehead in the middle above her nose. NA#1 asked the resident if she was OK and Resident #1 responded "yes." At the time of the incident, NA#1 explained there was a "red" spot on her forehead. She reported what happened to her nurse after the incident. NA#1 further explained the incident occurred around 10:00 AM during her "first rounds." Continued interview revealed NA#1 had not called for assistance due to the second NA on the floor was providing a shower and the nurse was at the desk.</p> <p>Interview with Nurse #1 on 3/15/17 at 12:29 PM who was working as the charge nurse for Resident #1 on 3/10/17 revealed she was informed by NA#1 during incontinence care, she was rolling Resident #1 over and hit her head. She explained NA#1 informed her the resident had a red area on her forehead. Nurse #1 initiated neurological checks which were done every 15 minutes for one hour, then every 30 minutes for an hour. Nurse #1 explained she had checked Resident #1 and she had "just a red spot" and the neurological checks were within normal limits. Further interview revealed Resident #1 could talk with you if she wanted to, and she told Nurse #1 she was "OK." From 10:00 AM to 12:00 PM she had a red spot on her forehead. Around 12:00 PM a hospice aide informed her Resident #1 had a nose bleed and there was a knot on her head. Nurse #1</p> | F 323 | | | |

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| F 323 | <p>Continued From page 5</p> <p>explained this was a change in condition, and the resident said her head hurt. Further interview revealed Nurse #1 did a neurological check and found no changes. EMS was called and the resident was sent to the hospital for evaluation. Nurse #1 explained the resident ' s nose bleed was "just a little bit, just a stain on her nares, a trickle." Continued interview with Nurse #1 revealed she had not given the antianxiety medication to the resident when she worked.</p> <p>On 3/15/17 at 12:15 PM, NA #1 demonstrated the incident that happened on 3/10/17. The demonstration was conducted in the resident ' s room and in the presence of the Director of Nursing. The resident ' s bed had half side rails which had foam covering the top but not the side or the bottom part of the side rail. The side and bottom of the rail was exposed and was a hard metal surface. The top of the side rail had a foam covering, and was positioned facing the wall, away from the resident. NA#1 explained she was positioned on the resident ' s right side with the top of the side rail positioned towards the wall. NA#1 explained Resident #1 was a small woman, and was positioned in the middle of the bed with her head next to the side rail. The bed height was adjusted to about NA#1 ' s thigh level to provide care.</p> <p>Interview with hospice aide #1 at 2:49 PM on 3/15/17 revealed she provided care for Resident #1 on 3/10/17. She went into the resident ' s room to feed her lunch. The hospice aide #1 observed Resident #1 lying on her left side, and asked if she wanted lunch. Resident #1 said "no." The hospice aide #1 explained Resident #1 always ate a good lunch and that was a change. Hospice aide #1 asked the resident to roll over,</p> | F 323 | | | |

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| F 323 | <p>Continued From page 6</p> <p>and that was when she saw her (Resident #1 ' s) head. Hospice aide #1 described Resident #1 ' s head as having "little red streaks, like a scratch, really swollen, red, and was black and blue." Hospice aide #1 asked hospice aide #2 to go into the resident ' s room with her. The hospice aide #1 looked for the floor nurse and could not find her and called her hospice nurse supervisor. The floor nurse was informed about the bruising and swelling on her head and came to Resident #1 ' s room. Both hospice aide #1 and #2 assisted with transferring Resident #1 to the EMS stretcher. Further interview revealed when the sheets were changed after the resident left the facility, neither hospice aide saw any blood on the sheets from the nose bleed.</p> <p>Continued interview with hospice aide #1 revealed Resident #1 had behaviors at times during care. The aide described her behavior was exhibited when you start messing with her finger nails to clean them. Hospice aide #1 explained Resident #1 would clinch her hand into a fist. Other behaviors were described as swatting with her arms, and she might kick a little. Resident #1 did not like to have her hair or nails cleaned. Before being transferred out of the facility on 3/10/17, hospice aide #1 was going to clean her fingernails due to something was under them. Her hospice nurse had arrived and told them not to, it was "agitating her."</p> <p>Interview with hospice aide #2 at 3:11 PM on 3/15/17 revealed she had provided care for Resident #1 one time by herself. Further interview revealed when she attempted to clean hands, and the resident told her to leave them alone. During the interview, hospice aide #2 explained she had rolled her back and forth</p> | F 323 | | | |

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| F 323 | <p>Continued From page 7</p> <p>during incontinence care without any problems.</p> <p>Interview with the hospice nurse at 11:30 AM on 3/16/17 revealed she arrived at the facility around 12:15 PM on 3/10/17. Further interview revealed she had observed Resident #1 in her room and she had a raised area on her forehead and dried blood on her nose. The hospice nurse explained Resident #1 was alert, and said her head hurt. While the hospice nurse was in Resident #1 ' s room, EMS arrived and transported her out of the facility. Interview with the hospice nurse revealed the resident would become agitated during care at times, mostly when hand hygiene was provided.</p> <p>Interview with the MDS nurse on 3/16/17 at 11:45 AM revealed she was not aware Resident #1 had any behaviors or resisted care. During the assessment timeframes there had not been any documented refusals.</p> <p>Interview with the Director of Nursing on 3/15/17 at 12:00 PM revealed she would expect staff to attempt to calm an agitated resident first. If the resident continued to be agitated, she would expect the staff to wait, leave the resident and come back or obtain assistance if care had to be provided.</p> <p>Interview with the social worker on 3/16/17 at 12:00 PM revealed she was not aware Resident #1 had any behaviors or resisted care. During the assessment timeframes there had not been any documented refusals.</p> <p>Interview with the primary physician on 3/16/17 at 12:30 PM revealed she was informed the resident was sent to the hospital due to a head injury.</p> | F 323 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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