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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/24/17 through 10/26/17. Past-noncompliance was identified at: CFR 483.25 at tag F323 at a scope and severity (J) The tag F323 constituted Substandard Quality of Care. Past-non compliance began on 10/21/17. The facility came back in compliance effective 10/23/17. An extended survey was conducted.	F 000	Past noncompliance: no plan of correction required.	
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (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. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		11/2/17

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

Electronically Signed | 11/02/2017

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F 323	Continued From page 1 the resident or resident representative and obtain informed consent prior to installation. (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, record review, family and staff interviews, the facility failed to prevent injury for one of three residents, Resident #6, who was at risk for injury related to a history of falls. Resident #6's last fall at the facility resulted in the resident being hospitalized for a skull fracture, brain bleed, and a cut to the back of the head requiring staples to close the wound. The findings included: Resident #6 was admitted to the facility from the resident's home on 10/19/17 and discharged to the hospital on 10/21/17. Diagnoses included, in part, repeated falls, Alzheimer's disease, anxiety, atrial fibrillation, and dementia. Resident #6's care plan had been initiated on 10/19/17 and had two care areas. The resident was care planned for being at risk for adverse effects from psychotropic medications such as low blood pressure, mood disorders, further falls, and gait disturbances. Interventions included, in part, assist resident to common area for increased visualization, bed/chair alarm at all times to alert staff at attempt with independent mobility, monitor resident's gait for steadiness, and provide activities to entertain resident during periods of restlessness. The second care area was in regards to addressing the resident's pain and discomfort.	F 323	Past noncompliance: no plan of correction required.	

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A review of the Admission Data for Resident #6 dated 10/19/17 revealed the resident had the following: Problems with balance, a diagnosis of repeated falls, required extensive assistance for transfers (i.e. from the bed to a wheelchair), incontinence, his cognitive status varied through the day, he was admitted with skin tears to the left shoulder, right and left arm, and right and left leg, and under the comment section it was documented the family reported to the facility the resident would try to get up unassisted.

A review of the Fall Risk assessment for Resident #6 dated 10/19/17 revealed the resident was at a high risk for falls related to cognitive impairment, requiring assistance for balance for mobility, requiring extensive assistance for transfers (i.e. from the bed to a wheelchair), he utilized a wheelchair for mobility, incontinence, and receiving a psychotropic medication.

A nursing note dated 10/20/17 stated Resident #6 had a fall in the sunroom and experienced a skin tear to the left arm. The injury was treated at the facility.

Another nursing note dated 10/20/17 stated at 8:25 PM Resident #6 had gotten up out of his wheelchair and was attempting to ambulate without assistance at the nurses' station. A nurse who witnessed the fall was unsuccessful to intervene and prevent the resident from falling. The resident suffered a cut to the forehead and was sent via ambulance to the Emergency Room (ER) at the local hospital at 8:35 PM.

A nursing note dated 10/21/17 stated at 1:10 AM stated Resident #6 returned from the ER via ambulance. A computerized tomography (CT)

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scan completed at the hospital was reported as having been negative. The resident had sutures to the forehead. It was documented the resident was assisted to bed, a pad alarm was in place, and frequent checks for safety were in progress.

A nursing note dated 10/21/17 stated at 1:15 AM Resident #6's bed pad alarm had been heard to sound several times within a few minutes. The resident was noted to be attempting to get out of bed without assistance. The resident was assisted out of bed to the wheelchair, assisted to the bathroom, and brought into the day room. The note further stated, "Constant one to one (1:1) in progress."

A nursing note dated 10/21/17 stated at 3:40 AM Nursing Assistants (NAs) were providing constant 1:1 for Resident #6 in the day room. The resident was noted to be dozing off to sleep. The NAs left the resident unsupervised to answer call lights. The nurse had gone to another nurses' station in the building. When NA #2 came out of a resident's room she observed Resident #6 had stood up from his wheelchair and was walking near the nurses' station. NA #2 observed the resident fall before she could reach him to intervene. Resident #6 fell backwards and hit the back of his head. The resident suffered a cut to the back of his head and a hematoma, a localized collection of blood under the skin. The resident had a noted decrease in level of consciousness. A dressing was applied to the wound to the back of the resident's head. The resident was sent to the ER at the local hospital via ambulance.

A review of Resident #6's hospital record with an admission date of 10/21/17 revealed a CT exam which read in part, the CT scan of the head was

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compared to the CT scan of the head dated 10/20/17. The findings of the CT of the head from 10/21/17 included acute bleeding of the brain and skull fracture, hematoma, and a cut with staples to the back of his head. The CT scan of the head dated 10/20/17 did not show a skull fracture or hematoma and was documented by the ER physician as being unremarkable. The resident was documented as having been unresponsive or poorly responsive for his admission and stay from 10/21/17. The hospital social worker was consulted for a hospice referral as well as an inpatient consult for palliative care. The resident was evaluated by the speech therapist at the hospital. The recommendation from the speech therapist was due to brain injury the resident was at very high risk for aspiration pneumonia. The speech therapist recommended the resident only receive very limited ice chips while under nursing supervision, no food and no liquids. The resident was discharged to a local hospice facility with comfort measures only on 10/23/17 including diagnoses of an injury which caused the brain to bleed and skull fracture. The resident was documented as having been lethargic and unable to respond to pain stimulus at the time of discharge.

An interview conducted with NA #1 on 10/24/17 at 4:05 PM revealed she was familiar with Resident #6. She stated he would not sit still, she remembered having to tell him to sit down quite a few times on 10/20/17 during the 3-11 shift. She stated she had assisted him to the bathroom and he needed assistance due to being unsteady on his feet.

An interview conducted with NA #3 on 10/25/17 at 10:33 AM revealed she had worked with Resident

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#6 on 10/19/17 and 10/20/17. The NA stated she was working on 10/19/17 when Resident #6 was admitted. The NA had talked with the resident's family and a caregiver who had been assisting the resident at home prior to admission to the facility. The NA stated the resident had bruises on his arms and legs. The caregiver told the NA the resident had fallen at home and was being admitted to the facility because he had many falls at home and the resident's family could no longer take care of him at home. She further added the resident was unsteady when he would stand and walk and he had a pad alarm for his wheelchair and bed.

An interview conducted with the unit manager on 10/25/17 at 10:47 AM revealed she had completed the admission assessment for Resident #6 on 10/29/17. She stated the resident had several skin tears, to his shoulder, his legs, and arms. The Unit Manager stated the resident's family told her the resident fell a lot. The unit manager added the resident was fine initially with sitting in the wheelchair and then he started standing. The intervention put into place for the resident was a padded chair alarm for the resident to notify staff when the resident stood up. The Unit Manager stated the resident was unable to safely stand or ambulate on his own without assistance. The Unit Manager stated she made sure the NAs were aware the resident was a high fall risk. The Unit Manager recalled the resident was attempting to stand every 2-3 minutes and his chair alarm would signal he was attempting to stand. The Unit Manager further added she was aware the resident had fallen three times at the facility with the last fall having occurred at approximately 3 AM the morning of Saturday, 10/21/17, and he was sent to the hospital after

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the last fall.

A phone interview conducted with Nurse #1 on 10/25/17 at 12:30 PM revealed she was the nurse who was working from 7 PM on 10/19/17 through 7AM on 10/20/17 and Resident #6 was on her assignment. Nurse #1 stated Resident #6 became more anxious in the evening he exhibited sundowning behaviors, such as anxiety and wanting to go. The nurse stated in order to keep the resident safe she and the other two nursing assistants maintained the resident under direct supervision for his safety. She stated when she arrived on 10/19/17 Resident #6 was at the nurses' station and had fallen earlier in the day. The nurse said she tried to keep the resident with her and had tried to keep him near her medication cart. The nurse stated when she was completing her 8:00 PM medication pass the resident was sitting in his wheelchair at the nurses' station. The day shift nurse, who had worked 7 AM to 7 PM was finishing her charting at the nurses' station. Nurse #1 stated at about 8:40 PM Resident #6 had stood up and fallen at the nurses' station when the day shift nurse was present. She stated the day shift nurse was unable to reach the resident in time to keep him from falling and injuring himself. The resident sustained an injury of a cut to the forehead. The resident was sent via ambulance to the hospital. Nurse #1 then recalled Resident #6 returned to the facility via ambulance from the hospital at about 1:40 AM. The cut the resident had sustained to the forehead had been closed with sutures. The nurses added the resident seemed calm when he returned. The NAs assisted the resident to bed. The nurse then added about 15 minutes after the resident was assisted to bed, staff heard his bed alarm and the resident was

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standing at the doorway of his room. The resident continued to appear to be unsteady on his feet while standing or ambulating. The NAs assisted the resident to sit in his wheelchair. Nurse #1 stated she returned to her duties and told the NAs, NA #2 and NA #4, they would all have to take turns watching Resident #6. She added she told the NAs if a call light had to be answered, one NA was to stay with the resident. At approximately 3:15 AM, Nurse #1 went to another nurses' station. While at the other nurses' station, Nurse #1 stated she heard a scream. Upon returning to her nurses' station she stated she observed NA #2 and NA#4 on the floor by Resident #6 who was on the floor on his back and the back of his head was bleeding. The nurse stated Resident #6 was unconscious, he became alert momentarily, then returned to being unconscious. The nurse stated the approximate time of the fall was 3:40 AM. Nurse #1 further added the ambulance was called and the resident went out to the ER of the local hospital. Nurse #1 further added when she discussed what had happened with NA #2 and NA #4 she discovered NA #2 and NA #4 were both in the day room with Resident #6. She then stated NA #4 left the day room to answer a bed alarm shortly thereafter NA #2 then left Resident #6 unsupervised to answer a call light. She further added when NA #2 returned to check on Resident #6 he was walking and she witnessed him falling but was unable to reach him in time and she had screamed.

An interview conducted with NA #4 on 10/25/17 at 3:59 PM revealed she was working the night Resident #6 experienced his third fall. NA #4 recalled she, NA #2, and the resident were in the TV room. She stated they had tried several interventions with Resident #6 including watching

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TV, snacks, and walking with the resident. She stated she and NA #2 were staying with the resident due to his history of falls and it was agreed upon that Resident #6 needed to be supervised. She added the nurse informed her and the other NA she was going to the other nurses' station. NA #4 stated she heard a bed alarm and left NA #2 supervising Resident #6 so she could answer the alarm. NA #4 stated while she was in the bathroom with another resident she heard a chair alarm sound and thought it may have been Resident #6's chair alarm but she was unable to safely leave the resident she was with, she then heard NA #2 yelling. NA #4 added when she had finished assisting the resident she was working with she went to check on Resident #6. NA #4 further added she discovered Resident 36 to be on the ground, on his back, with a cut to the back of his head, he was unresponsive and NA #2 was with him.

A phone interview conducted with Resident #6's physician on 10/25/17 at 4:16 PM revealed Resident #6's family was having a very difficult times taking care of him because of his confusion. The resident's family admitted him to the nursing home because of his decline and falls; the resident needed 24 hour a day care. The doctor stated the resident had suffered a skull fracture with an intracranial bleed after his fall. The doctor further added the intracranial bleed caused by the fall led to the resident's hospitalization and his admission to a local hospice facility.

A phone interview conducted with NA #2 on 10/25/17 at 4:42 PM revealed she was working from 11 PM to 7 AM the night Resident #6 experienced his third fall. NA #2 stated she

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remembered Resident #6 being up in the wheelchair and she and NA #4 were supervising him and another resident who was also trying to stand. NA #2 stated, she, NA #4, and the two residents were all in the TV room. NA #2 stated it was a mutually agreed upon decision to maintain direct supervision of Resident #6 due to his falls and he kept trying to stand up, according to NA #2 every couple of seconds. NA #2 stated she remembered NA #4 went to answer a call light. NA #2 stated Resident #6 was drowsy and started to go to sleep while he was sitting in the wheelchair in the TV room. NA #2 stated she had to answer a call light and left Resident #6 unsupervised. NA #2 then stated when she was assisting another resident she heard a pad alarm sounding and after she finished assisting the other resident she returned to the nurses' station and discovered Resident #6 had stood up from his wheelchair and was walking unassisted. NA #2 further added she observed Resident #6 start to fall and she screamed. NA #2 stated she saw Resident #6 fall backwards and hit his head. NA #2 finally added there was no individual who was assigned to supervise Resident #6 and she did not think he would get up in the short time it took her to answer the call light.

On 10/25/17 at 5:05 PM, an interview was conducted with the Administrator and the Chief Operating Officer. They stated they had initiated an in-service for nursing staff and put a Plan Of Correction (POC) in place. He stated the facility had put an audit system into place as to interventions which have been put into place to decrease fall risk. The Administrator stated there were no residents at the facility who were receiving one to one supervision in the facility at that time.

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The corrective action for past non-compliance dated 10/23/17 was as follows:

1. The resident fell while in the facility Sunroom after getting up unassisted on 10/20/17 at approximately 3:00 PM. Interventions put into place at that time include a medication review by the pharmacy consultant who was onsite for a QA meeting. Nursing staff, including the RN Clinical Specialist and pharmacy consultant, ambulated the resident at that time as part of their post fall interventions. Thereafter, the nursing staff also started increased monitoring for the resident in common areas of the facility. Resident fell again at 8:25 PM while at the Nurse's station (a common area). This second fall occurred while the resident was standing unassisted from his wheelchair. A nurse was directly across from the resident at the Nurse's station at the time of this fall; however, the resident stood up and fell forward suddenly. After an assessment by the nurse, the resident was sent to the ED for evaluation and treatment. The resident returned to the facility at approximately 1:50 AM on 10/21/17. Upon returning to the facility, the resident's nurse and nursing assistant started 1:1 and diversional activities including engaged conversation, snacks, toileting, ambulation and watching TV with the resident beside the nurse's station. The 3rd fall occurred on 10/21/17 when nursing staff members (nurse and certified nursing assistants) temporarily stepped away from 1:1 monitoring with the resident for a period of time believed to be up to approximately 2 minutes (resident was still watching TV in the open room beside the nurse's station at this time). This time estimation is derived from interviews by the administrative team of relevant

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nursing staff who were providing care for the resident at that time. Nursing staff members each verbalized during the interviews that they believed the resident was safe while they briefly stepped away to provide care for another resident on the hallway. The resident was transported to the hospital and never returned to the facility. Were the resident to return, the facility would initiate 1:1 monitoring as a baseline intervention until it could be determined and documented that the resident did or did not require 1:1 monitoring.

The facility believes the nurse in charge of the resident at the time of the event in question could have better elaborated and communicated to the nursing assistants her expectations that resident should not be left alone (as a part of the 1:1 monitoring which was put into place to promote resident safety). The nursing staff had been conducting 1:1 monitoring for this resident (in addition to other and previous fall prevention interventions already in place that are listed above); if the nurse had specified that the resident in question could not be left unattended, even briefly with a pad alarm in place, the fall likely would not have occurred. To clarify, the facility does not believe the event in question is a failure to implement fall prevention interventions.

2. The facility created a new QI team, referred to here as the 1:1 Monitoring QI Team, to direct and implement this plan of correction. The team was formed and met for the first time on 10/23/17. Team members include the Nursing Home Administrator, Director of Nursing (on medical leave at this time), a Unit Coordinator, Corporate Representative and facility Clinical Specialist. Additional members can be added at the discretion of the facility administrator as/if

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needed. This QI team collaborated to create the in-service, the schedule for in-servicing nurses, the QA tool (the 1:1 QA Monitoring Tool) for monitoring and the review of current residents for possible 1:1 monitoring needs or a change in fall prevention interventions.

To address this issue and to prevent future similar issues:

The facility initiated a 100% nursing staff in-service meant to elaborate and clarify that it is the responsibility of the nurse to ensure fall prevention interventions, including 1:1 monitoring expectations, are clearly communicated to nursing assistants and other nursing staff members (nurses for example).

The facility also created a QI team to continuously review and monitor the interventions put into place specific to a plan of correction.

The facility QI team initiated work to create an improved system of implementation and follow up on fall prevention interventions. This substantial document will be implemented with nursing staff as soon as it can be finalized. It is in addition and to meant to supplement previous interventions already in place as part of a continuous quality improvement project document.

The facility (1:1 Monitoring QI team members) reviewed all current residents on 10/23/17, looking to determine if any other residents were in need of or receiving 1:1 monitoring. As of 10/23/17, no other residents are receiving or are in need of 1:1 monitoring for fall prevention intervention (or other purposes).

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	345330	A. BUILDING _____ B. WING _____	C 10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

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This determination was made using a team approach to discuss and review each resident currently in the facility. Tools/resources utilized in this determination discussion include resident observations, staff interviews, chart reviews and Incident/Accident report review(s). The purpose or goal of the review/audit was to determine if any other residents would be in need of 1:1 monitoring OR any new/ different fall prevention intervention. The Clinical Specialist (RN nurse in charge of Incident/Accident reviews at this time) led this discussion amongst the 1:1 Monitoring QI team members on 10/23/17 including any follow up areas. The facility also checked to make sure that fall prevention interventions were being followed for all other residents and found them to be in compliance.

The facility (1:1 Monitoring QI team members) reviewed all current residents on 10/23/17, looking to determine if any other residents were in need of or receiving 1:1 monitoring. As of 10/23/17, no other residents are receiving or are in need of 1:1 monitoring for fall prevention intervention (or other purposes). This determination was made using a team approach to discuss and review each resident currently in the facility. Tools/resources utilized in this determination discussion include resident observations, staff interviews, chart reviews and Incident/Accident report review(s). The purpose or goal of the review/audit was to determine if any other residents would be in need of 1:1 monitoring OR any new/ different fall prevention intervention. The Clinical Specialist (RN nurse in charge of Incident/Accident reviews at this time) led this discussion amongst the 1:1 Monitoring QI team members on 10/23/17 including any follow up areas. The facility also checked to make sure

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that fall prevention interventions were being followed for all other residents and found them to be in compliance.

3. The facility created and initiated an in-service on 10/23/17 for all nurses, medication aides and nursing assistants who are currently on the active payroll. The in-service was created during a QI team meeting discussion on 10/23/17 that was prompted and led by the facility administrator. The in-service was provided to the nursing staff and directed by the facility Clinical RN Specialist and the Nurse Unit Coordinators. Starting on 10/23/17 and moving forward, any nursing staff employee who has not been in-serviced will be in-serviced upon their return to the facility for their next scheduled shift. This will be continued until 100% of nursing staff members are in-serviced. Future new hires will be in-serviced as part of their general orientation process prior to being released from orientation/probation. The facility administrator will direct and monitor this area for compliance until the D.O.N. returns from medical leave. The in-service to the nursing staff was specific to the event in question on 10/21/17. The information provided to the nursing staff is meant to help prevent any future deficient practice in this area of fall intervention prevention. Specifically, the nurses were instructed to clearly communicate any changes in fall prevention interventions, including the need for 1:1 monitoring. The nurses were re-educated that, if an intervention is changed (modified up or down depending on what is needed and necessary to promote safety), to then make sure they have communicated that information to staff members they are working with and to document that information accordingly so the rationale or logic can be followed by others. Nurses were also

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educated to pick the fall prevention intervention(s) which they believe are most appropriate based on the resident's specific needs, including 1:1 monitoring.

As an overview of the actions by the facility when a resident falls, a charge nurse assesses and documents the fall in the nurse's notes and on an incident accident QI report. This documentation triggers activity within the Electronic Medical Record (EMR) system, including fall prevention intervention communication and resident care planning. This course of action occurs for any resident fall as a standard part of the facility post fall process. Additional interventions are assessed/re-assessed on an ongoing basis as determined by the resident's needs. For QA purposes, the facility monitors and analyzes all resident falls utilizing the aforementioned incident accident form/QI tool. This tool, which is populated from information by the charge nurse(s), is the starting point for enabling the facility to analyze and determine root cause(s) on a resident by resident basis. The QA Fall Intervention Monitoring Tool, is maintained and managed by the Administrative Nurses and reviewed daily. The Administrative Nurses continue to use the tool to assess and ensure compliance with fall prevention interventions such as 1:1 monitoring, bed alarms, bolster mattress covers, bolster pillows, high winged mattresses, low beds, etc. The QI team meets weekly to review and discuss these processes.

4. The QI team met on 10/23/17 and will meet again prior to 10/27/17 and again on 10/30/17. The purpose of these QI meetings being to gauge the plan of correction progress and to ensure ongoing compliance. The QI team will meet at

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least weekly for the next 12 months, most likely during the weekly administrative nurse's meeting where care issues are reviewed. The Administrator will be responsible for chairing this QI team in addition to assigning new members, changes or updates to the plan of correction and the responsibility of ensuring monitoring of fall prevention interventions including 1:1 interventions. Note: the facility will continue to assess this internal plan of correction and reserves the ability to add or adjust to this plan of correction. For example, expanded nurse staff training and systematic approaches for staff to implement and follow that may be needed to ensure continued compliance. These documents and facility interventions will be added and reflected in the QI meeting minutes.

As part of the validation process on 10/24/17 through 10/26/17, the plan of correction was reviewed including the re-education of staff and observations of interventions put into place to minimize the risk of falls. Resident #6 did not reside in the facility at the time of the investigation. Observations of interventions for other residents were conducted on 10/26/17 and all were appropriately in place. Interviews with licensed staff and nursing assistants revealed they were retrained in the areas of 1:1 supervision and nurse directives for interventions put into place. A review of the monitoring tools revealed that the facility completed the audit of falls as noted in their POC. Due to the brief period of time between the incident, the intervention of the POC, and the complaint investigation in-servicing of remaining nursing staff remained ongoing as of 10/26/17. The facility showed additional documentation that provided information that included in addition to

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F 323	Continued From page 17 in-servicing staff prior to their shift starting they had started in-servicing staff not at the facility over the phone. In-service documentation review included NA #2, NA #4, and Nurse #1 who were involved with Resident #6 from 10/19/17 and 10/20/17. A review of the audit tools revealed audits for one to one monitoring had been not been conducted due to there being no residents with one to one monitoring. The administrator reviewed the one to one tool and how it would be put into place and be utilized in the event one to one supervision was necessary for a resident. The facility alleges full compliance with this plan of correction effective 10/23/17.	F 323		