STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING ______ B. WING ______	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	**250 LOVERS LANE WASHINGTON, NC 27889**

(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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to place a fall mattress next to a resident's bed prior to leaving the resident alone while in bed, which resulted in a fall with a skin tear for 1 of 3 residents reviewed for falls. (Resident #5) Findings included: Resident #5 was admitted to the facility on 1/18/13. Her active diagnoses included anemia, heart failure, hypertension, dementia, and atrial fibrillation. Review of Resident #5's minimum data set assessment dated 11/15/18 revealed she was assessed as severely cognitively impaired. She required extensive assistance with bed mobility, dressing, and eating. Resident #5 was totally dependent on staff for transfers, locomotion on and off unit, toilet use, and personal hygiene. She was always incontinent of bowel and bladder. She had sustained one fall with no injury since prior assessment. She received an anticoagulant 6 days of the 7 day look back period. Review of Resident #5's care plan dated 11/15/18	F 689	River Trace Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. River Trace Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, River Trace Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that led to this deficiency was the facility failed to place a fall mattress next to a resident's bed prior to leaving the resident alone while in bed, which resulted in a fall with a skin tear for	1/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/14/2019

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 689	Continued From page 1 revealed she was care planned to be at risk for falls. The interventions included to use a lift for transfers and to place a regular bed mattress on the floor beside the bed while the resident was in bed. Review of a nurse's note dated 12/15/18 revealed Resident #5 sustained an unobserved fall. The nurse was called to the room and Resident #5 was noted to be lying on her left side with a moderate amount of bright red blood on the floor. The bed was in the lowest position. The nurse performed an assessment which revealed a large laceration above Resident #5's left eyebrow. Resident #5 was alert and verbal and voiced no complaints of pain. The resident stated she was trying to go to the bathroom. Resident #5 was then ordered to be sent to the emergency department for evaluation. Resident #5's responsible party was notified. Review of a nurse's note dated 12/15/18 revealed Resident #5 returned to the facility with no signs or symptoms of distress. A dressing was noted to the upper left brow area. The resident's respirations were even, and unlabored and vital signs were stable. There were no further injuries identified during the hospital stay. During an interview on 1/2/19 at 11:47 AM Nurse Aide #1 stated on 12/15/18 she gave Resident #5 her bath, dressed her, put her shoes on her and the resident required the use of a mechanical lift for transfers. She stated there was safety mattress that was to be next to the resident's bed when she was in bed for fall safety. The NA stated she removed the mattress to provide morning care. She stated when she finished the morning care and she lowered the resident's	F 689	1 of 3 residents reviewed for falls. (Resident #5) The fall mattress beside Resident#5□s bed was replaced on 12/15/18 by the 100 Hall Nurse while Resident#5 was resting alone in bed. NA#1, an agency employee no longer works with the facility. On 12/17/18, the Director of Nursing (DON) conducted 100% audits of residents to include resident #5 who were care-planned to have fall mats/mattresses besides their bed to check to see if the fall mats/mattresses were in place. The Director of Nursing (DON) addressed any issues during the audits. On 1/8/19 100% return demonstration for safety interventions was initiated by the Staff Facilitator Nurse utilizing the Return Demonstration-Safety Interventions Tool with all nurses, Nursing Assistants (NA) to include agency NAs, Therapy Director and therapy staff to ensure that staff replace all safety interventions, to include fall matts/mattresses, before leaving a resident□s room for any reason to include retrieving a lift pad or lift whenever a resident is un-supervised. All areas of concern will be immediately addressed by the Staff Facilitator to include placement of appropriate safety interventions and education of staff. Return Demonstrations will be completed by 1/17/19. After 1/17/19, no Nurse, NA to	

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F 689	Continued From page 2 bed back down to its lowest potion. She then stated she had to remove the safety mattress from the resident's room in order to move the mechanical lift into the room. She stated she propped the safety pad to the side of the wall and went to get the mechanical lift pad and came straight back to the resident's room which took a little under a minute. Nurse Aide #1 stated she left Resident #5 alone in her room at that time. When she returned to the room she saw Resident #5 was on the floor lying beside her bed on her left side. She stated Resident #5 was bleeding from the left side of her head. She stated she immediately stepped back out and told a nurse aide to call the nurse on the hall. She stated she then went back into the room and the nurse came to the room and did an assessment on the resident and then called 911 and Resident #5 went to the hospital. She further stated she asked Resident #5 what had happened, and she said she had needed to go to the bathroom. She further stated she had not known Resident #5 to get up often and felt she would be able to quickly go down the hall and return to the resident's room without any issues. She further stated it did not dawn on her to put the floor pad back next to the resident's bed while leaving Resident #5 unattended to get the lift pad because she had not worked with Resident #5 often and felt she would not leave the resident long. She further stated the care plan was to be used to identify what care each resident needed and Resident #5 was care planned to have a mattress next to her bed while she was in bed. During an interview on 1/2/18 at 1:03 PM the Director of Nursing stated the fall mattress should have been replaced by Nurse Aide #1 prior to leaving Resident #5 unattended on 11/15/18. She	F 689	include agency NA, therapy director, or therapy staff will be able to work until return-demonstration is completed. On 1/8/19 100% in-service was initiated by the Staff Facilitator with all nurses, nursing assistants (NAs) to include agency NAs, Therapy Director, and therapy staff in regards to Safety Interventions to include: 1. Staff should keep all safety interventions in place until ready to provide care 2. Staff should replace all safety interventions to include fall mat/mattress beside a resident□s bed before leaving the resident□s room for any reason to include retrieving lift or lift pad. In-service will be completed by 1/17/19. After 1/17/19, no Nurse, NA to include agency NA, therapy director, or therapy staff will be able to work until in-service is completed. All newly hired nurses, NAs to include Agency NAs, Therapy Director, and therapy staff will be in-serviced by the Staff Facilitator during orientation on Safety Interventions to include: 1. Staff should keep all safety interventions in place until ready to provide care 2. Staff should replace all safety interventions to include fall mat/mattress beside a resident□s bed before leaving the resident□s room for any reason to	

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F 689	Continued From page 3 concluded it was her expectation Nurse Aide #1 had followed the care plan and left the mattress at the bedside while Resident #5 was in bed prior to leaving to getting the mechanical lift sling and she did not. During an interview on 1/2/18 at 1:15 PM the Administrator stated it was his expectation Nurse Aide #1 would have placed the fall mattress back beside Resident #5's bed prior to leaving to get the mechanical lift swing and she did not.	F 689	include retrieving lift or lift pad. MONITORING 10% audit of NAs to include agency NAs, nurses, and/or therapy will be observed providing care to residents at risk for falls, to include resident#5. This audit will completed by the Treatment Nurse, Nurse Supervisor, Assistant Director of Nursing (ADON), Director of Nursing (DON) and the Staff Facilitator utilizing the Safety Interventions Audit Tool weekly X 8 weeks then monthly x 1 month; to ensure staff are keeping all safety interventions in place to include fall mat/mattress until they are ready to provide care and that all safety interventions are put back into place before leaving resident room for any reason to include retrieving lift or lift pad whenever a resident is un-supervised. All areas of concern will be immediately addressed by the Treatment Nurse, Nurse Supervisor, Assistant Director of Nursing (ADON), Director of Nursing (DON) and the Staff Facilitator to include replacing appropriate safety interventions and re-education of staff. The Administrator will review and initial all Safety Interventions Audit Tools weekly x 8 weeks then monthly x 1 month to check for completion and ensure that all areas of concern were addressed. The Administrator will forward the results of the Safety Interventions Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review Safety Interventions Audit Tool to	

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F 689	Continued From page 4	F 689	determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	