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	345175	A. BUILDING _____ B. WING _____	C 03/15/2019

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F 000	INITIAL COMMENTS The survey team entered the facility on 3/14/19 to conduct a complaint survey and exited on 3/15/19.	F 000		
F 689 SS=G	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, observation, resident interviews, staff interview, and physician interview, the facility failed to prevent residents from rolling out of the bed during care for 2 of 3 sampled residents who had a history of falls (Resident # 1 and # 3) resulting in a hip fracture for Resident #1 and Resident #3's toe nail coming off. The findings included: 1. Record review Resident # 1 was admitted to the facility on 7/2/13. The resident had diagnoses of Parkinson's disease, tremor, dementia, chronic obstructive pulmonary disease, and atrial fibrillation. The resident received anticoagulation therapy for her diagnosis of atrial fibrillation. Review of Resident # 1's quarterly Minimum Data Set (MDS) assessment, dated 12/20/18, revealed the resident was severely cognitively impaired. The resident was assessed to need extensive	F 689	NA #1 no longer employed. NA #2 shall receive individual formal counseling regarding fall occurring 3-4-2019 of Resident #1. Completion date will be no later than 4-5-2019. NA #3 shall receive individual formal counseling regarding fall occurring 1-23-2019 of Resident #3. Completion date will be no later than 4-5-2019. Resident #3 shall be assessed, have care plan reviewed and if deemed necessary, provided new interventions to include, but not limit, bed width extension kit no later that 4-5-2019. All current residents involved in one or more falls during the last 12 months shall be reviewed by the Fall Committee. Any residents involved in falls during ADL care or whom may be at risk for falls during ADL care shall be ordered two person assist with ADL care and corresponding	4/5/19

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

Electronically Signed | 04/04/2019

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F 689	Continued From page 1 assistance by two people with bed mobility. The resident was assessed to need total assistance of 1 staff member with hygiene and toileting. The resident was coded as having a history of one fall without injury since the last assessment. Review of Resident # 1's care plan, last revised on 2/26/19, revealed the facility had identified the following problem. "Resident is at risk for falls due to use of psych meds, anemia, dementia, incontinence, anticoagulant therapy." This problem had been originally added to the care plan on 6/19/18 and remained as an active part of the resident's 2/26/19 care plan. "Bed in lowest position" had been added as an intervention on 6/19/18 and remained an active intervention. "Impact mat to front side of bed," had been added to the care plan on 10/26/18, and remained an active intervention. There had been no added interventions to address falls for the resident since 10/26/18. The care plan also noted the resident needed assistance with activities of daily living. This had been added to the care plan on 6/19/18, and continued to be a part of the resident's 2/26/19 care plan. There was no notation on the care plan regarding the number of staff members needed to provide assistance for Resident # 1's activities of daily Living. Review of nursing notes revealed an entry dated 12/10/18 at 10:57 AM by Nurse # 1 with the following information. The resident had been observed on the floor at 9:45 AM on the right side of the bed. The NA (nurse aide) had reported she "was giving AM care went to wardrobe to get a brief and resident rolled out of bed." The resident sustained a skin tear, and complained of right hip pain. The physician and family were notified, and the resident was transferred to the hospital.	F 689	care plans updated to reflect such. The Falls Committee shall take place no later than 4-5-2019. Formal in-servicing entitled "Safety" shall be completed by Staff Development Coordinator to encompass all nursing staff members (RN, LPN, CNA.) In-service lesson plan shall include process for assessment and initiation of physician orders for residents requiring two person assist for ADL care, proper positioning of residents during ADL care, safety during care, awareness of care plan manuals and the "FYI" section of the electronic health record and being prepared at the start of ADL care. In-services shall be completed no later than 4-5-2019. Quality Assurance Coordinator and Falls Committee members shall review and audit each incident report and fall investigation report to ensure any needed new orders or interventions for residents who have fallen are initiated. Audits entitled "Safety Compliance Audit" shall be conducted by the Quality Assurance Coordinator and/or her designee. Audits shall ascertain knowledge and compliance of nursing staff members as it relates to the in-service "Safety." Audits shall be completed weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Initial audit shall be completed no later than 4-5-2019. Audits and findings of audits entitled "Safety Compliance Audit" shall be included and reviewed in the facility Quarterly Quality Assurance Committee. The committee consisting of, but not	

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F 689	Continued From page 2 Review of the facility's investigative report for this fall, dated 12/10/18, revealed the following description of the incident was noted. "Resident observed lying on R (right) side beside bed. Per CNA (nurse aide) was giving resident AM care. Went to wardrobe to get a brief and resident rolled OOB (out of bed). Skin tear to R elbow-ROM (range of motion) to all extremities c (with) staff assist (assistance)-Resident placed back in bed c (with) sheet underneath her. While dsg (dressing) skin tear to R elbow resident with c/o (complaints) R leg pain. Call placed to triage. Order received to send resident to ED (Emergency Department)." According to the investigative report, the bed had been in the elevated position at the time of the incident. There was no statement from the nurse aide who had been involved in the incident. There was no notation that the resident's position in bed, prior to the nurse aide leaving the bedside and the resident falling, was investigated. Review of the falls committee follow up report, dated 12/13/18, revealed the fall had been discussed. Under the section entitled "comments" a note had been added which read, "two person assist (assistance) with ADL (activities of daily living) care when increased restlessness is observed." The facility's QA (quality assurance) nurse was interviewed on 3/14/19 at 11:50 AM. The QA nurse reported the following. The 12/10/18 incident was discussed in the facility's weekly falls committee meeting on 12/13/18. The QA nurse verified the bed had been in the elevated care position when the resident fell on 12/10/18. The QA nurse stated the NA had not said how the	F 689	limited to Medical Director, Administrator, and Director of Nursing shall receive findings and aid in any measures needed to ensure understanding and compliance of in-service entitled "Safety Compliance Audit." The next Quarterly Quality Assurance Committee is scheduled to be conducted 4-16-2019.	

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resident was positioned in the bed at the time of the fall. According to the QA nurse, the resident was very small and only needed one person's assistance to turn and position her prior to 12/10/18. The falls committee discussed if two people should be required for assistance if the resident was restless, but this intervention was not initiated. The QA nurse stated the comment found on the falls committee follow up note which read, "two person assist (assistance) with ADL (activities of daily living) care when increased restlessness is observed," did not mean that this was initiated. It only meant that the intervention was discussed as a possibility at the meeting. After the 12/10/18 incident was discussed, it was determined that it was an isolated incident by the falls committee, and that the resident's current care plan would be continued without any needed modifications. The QA nurse was interviewed regarding safety practices the facility followed. According to the QA nurse, facility safety practices were determined by the DON and he would need to speak regarding that.

An observation of the semiprivate room, in which Resident # 1 resided until 3/4/19, was made with the DON (Director of Nursing) on 3/14/19 at 12:40 PM. According to the DON, the layout of the room was the same on 3/14/19 as when Resident # 1 had resided in it. According to the DON, Resident # 1 had resided in the first bed as you enter the room. The head of the bed was observed to be against the right wall as you entered the room from the doorway. On either side of the bed, there was open space which allowed for resident care. Another wall was approximately four feet away from the foot of the bed. On this wall were located the residents' sink and wardrobe. It was approximately six feet to the wardrobe/sink area

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from the bedside.

Nurse # 1 was interviewed on 3/14/19 at 2:00 PM and reported the following regarding the incident of 12/10/18. She had been the Nurse Team Leader on 12/10/18, and either NA # 1 or Nurse # 3 had called her to Resident # 1's room. When she entered the room, Resident # 1 was lying on the floor to the right of the bed (if facing the head of the bed from the foot of the bed). NA # 1 had reported to Nurse # 1 she had been giving Resident # 1 morning care. The NA had further reported she went to the wardrobe, and when she turned back around the resident was on the floor. At the time of the incident, the bed was in the elevated care position. Nurse # 1 did not recall if the resident was on the mat or not. The resident was assessed on the floor, and found to have a skin tear and no other obvious injury. They used a sheet to lift the resident into the bed, and Nurse # 3 (the floor nurse) immediately started dressing the resident's skin tear. During the care, the resident complained of pain in her hip. The physician was notified and the resident was sent to the hospital. Nurse # 1 reported Resident # 1 had generally "not moved too much and pretty much was total care." Nurse # 1 also reported that NAs had an information sheet (FYI sheet) that had the resident's care plan information and which the NAs accessed so that they were aware of care needs for residents.

Nurse # 3 was interviewed on 3/14/19 at 2:30 PM, and reported the following. Nurse # 3 was the floor nurse on 12/10/18. She had worked with Resident # 1 for two years, and had not personally seen her have the physical strength to independently turn herself over. Nurse # 3 reported Resident # 1 was stiff from her

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Parkinson's disease, and had both physical and cognitive limitations. On 12/10/18 Resident # 1's assigned NA # 1 alerted her that the resident was on the floor. Nurse # 3 recalled NA # 1 had reported to her that she (the NA) had turned around for something, and when she turned back around the resident was on the floor. Nurse # 3 stated the NA did not say how the resident was lying in the bed before she fell. Nurse # 3 entered the room and found the resident lying on the floor as if she had rolled out of bed. Nurse # 3 obtained the supervisor (Nurse # 1), and the resident was assessed before getting her back to bed. Once in bed, the resident patted her hip as if it hurt. The physician was called and the resident was transferred to the hospital.

According to an interview with the DON (Director of Nursing) on 3/14/19 at 12:40 PM, NA # 1 had been assigned to care for Resident # 1 on 12/10/18 and was with her when she fell. The DON stated NA # 1 was no longer employed at the facility. According to the DON, following the incident of 12/10/18, he had viewed it as an isolated incident. The DON felt that staff should be in attendance when a resident was in an elevated bed for care. The DON stated NA # 1 was in attendance, and she had stepped to the wardrobe. The DON stated the distance between the foot of the bed and the wardrobe was similar to the distance between the bedside and the foot of the bed. The DON stated on older beds, there used to be a crank to lower the bed, and staff would have to step to the foot of the bed to lower the bed. Therefore directly following the incident, he had not viewed the NA stepping to the wardrobe as different from a staff member going to the foot of the bed when crank beds were utilized. The DON acknowledged that at the time

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of the 12/10/18 incident, the bed had a remote control to lower and elevate its height.

An attempt was made to call NA #1 on 3/14/19 at 12:55 PM, and she could not be reached.

Review of Resident # 1's hospital discharge summary, dated 12/13/18, revealed Resident # 1 had been identified to have a right hip fracture upon her hospital admission. The hospital discharge summary also noted "fractures of the right superior and inferior pubic ramus (pelvis) are also suspected." There was documentation by the radiologist which noted the resident had severe osteopenia and this limited the diagnostic evaluation of the pelvis. Resident # 1 was hospitalized from 12/10/18 to 12/13/18, and underwent surgical repair of the hip fracture.

Review of facility records revealed Resident # 1 was readmitted to the facility on 12/13/18 for care.

Review of physical therapy documentation revealed Resident # 1 received physical therapy services from 12/14/18 to 12/24/18. Review of the physical therapist's initial evaluation, dated 12/14/18, revealed the resident had required total assistance with bed mobility prior to her surgery, and continued to do so.

The physical therapist (PT) was interviewed on 3/14/19 at 11:30 AM, and reported the following. The resident had cognitive and physical limitations which limited her ability to move and participate in therapy. While he worked with the resident, he had never witnessed the resident to turn herself independently in bed. While working with the resident he would tell her he was going to

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help her turn over. The resident would initiate some movement by reaching her hand or turning her head towards him, but then never carried through with actually turning. She had always required his assistance to completely turn in bed, and he was able to safely turn her himself while working with her.

Review of hospital records revealed the resident was hospitalized again from 1/21/19 to 1/25/19 secondary to displacement of her right hip hardware due to osteoporosis. The resident underwent a second right hip surgery on 1/23/19.

According to facility records the resident returned on 1/25/19 for care at the facility. Review of the resident's care plan revealed no updates to her care plan in regards to falls and safety while in bed.

Review of nursing notes revealed an entry on 3/4/19 at 11:06 PM noting Resident # 1 had sustained a second fall from the bed while a staff member was caring for the resident. Nurse # 2 documented at this time, "Pt. noted to be on floor beside bed, after rolling off bed during change. Has small skin tear on right arm. Cleansed and covered. Pt alert and talking. T (temperature) 97.8, P (pulse) 88, R (Respirations) 20, B/P 100/62. Pt assisted back to bed with dependent lift."

Nurse # 2 did not document the time the resident rolled out of bed in the medical record.

According to a facility investigative report, the incident occurred on 3/4/19 at 8:00 PM. Nurse # 2 documented under the section entitled "description of what happened" the following. "Pt

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(Patient) noted to be on floor beside bed on side-alert-responsive-Skin tear R (right) lower elbow area. No other bleeding-No C/O (complaint of) pain." There was no notation in regards to how the resident was positioned before the fall. The investigative report had the bed was in the low position.

In an interview with the DON on 3/14/19 at 11:10 AM, the DON validated the bed had been in the elevated waist level care position when the resident rolled out of the bed on 3/4/19, and the fall at occurred at 8:00 PM.

NA # 2 was interviewed on 3/14/19 at 3:10 PM. NA # 2 had been assigned to care for Resident # 1 on the evening shift of 3/4/19. NA # 2 reported she had worked at the facility since September, 2018 and prior to 3/4/19, she had not cared for Resident # 1 since her September orientation. She therefore was not very familiar with her when she was assigned to care for her on 3/4/19. She knew there was a "FYI" (For Your Information) sheet that described resident's care needs, but had not looked at it that evening before caring for Resident # 1. The other NAs had told her that the resident was a "one person assist." The resident had appeared okay at the beginning of the evening. Later in the shift she was giving Resident # 1 incontinent care. She had the resident turned on her left side, and the NA validated the bed was elevated to her (the NA's) waist level for care. She realized she had forgotten her washcloths, and she went to the sink to get them. While her back was to the resident, she heard the resident fall from the bed which was still at the elevated care position level. She turned, and saw that the resident was on the floor mat beside of the bed. She called for help.

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Another NA, Nurse # 2, and Nurse # 4 all came. The resident was talking in her confused manner and looking around. After the nurses checked the resident, she and the other NA assisted the resident back to bed with the lift and got her changed. When she left the resident, the resident was looking around and had her eyes open. The NA was interviewed regarding whether she had been aware on 3/4/19 that Resident # 1 had fallen in December, 2018 and sustained a hip fracture when another NA had left the bedside. The NA replied she had not known this on 3/4/19, and if she had, she would have gotten help before caring for Resident # 1 on 3/4/19.

Nurse # 2 was interviewed on 3/14/19 at 4:50 PM, and reported she was the supervisor for the evening of 3/4/19. She stated she had been called to Resident # 1's room at 8:00 PM by the floor nurse (Nurse # 4). The resident was lying on the floor mat facing the door. NA # 2 had reported that she had turned the resident, and for a few seconds there had been a time when her eyes were not on the resident, and the resident had fallen. She checked her head, and did not find any evidence of head trauma. She checked her entire body for injuries, and other than a skin tear to the arm did not find any. The resident's pupils were normal and her vital signs were checked. After she thoroughly made sure the resident was okay, she instructed the NAs they could get the resident back to bed with the lift. She then went to complete paperwork related to the fall. She returned to the room around 8:30 PM. She looked at the resident's pupils, and they appeared to be normal. She again checked the resident's body, and did not see any evidence of problems.

Nurse # 4 was interviewed on 3/14/19 at 4:20 PM

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and reported usually Resident #1 would lay "straight in the bed unless you moved her," and she had never seen her move herself in bed. On 3/4/19, Resident # 1 appeared her normal self at the beginning of the shift. NA # 2 had come to get her help later in the evening, and told her the resident "had rolled off the bed." She obtained the help of Nurse # 3, and when she entered they found the resident lying on the floor on her left side facing the door. The resident had a "skinned area" on her hand but otherwise appeared okay upon assessment. Later she (Nurse # 4) checked the resident around 8:30 PM, and her eyes were open. She did not speak, but that was not unusual for the resident.

The physician, who also served as the facility's medical director, was also interviewed on 3/15/19 at 1:12 PM regarding safety and the resident's falls. The Physician stated when Resident # 1 initially fell on 12/10/18 she had "struggled" to understand how this could have occurred. The Physician stated the resident was pretty much immobile because of her Parkinson's disease. The Physician stated that after the resident fell a second time, she felt the facility staff needed to really review and change the way they were doing things. She stated the staff needed to be prepared with things they needed for care, and have them in reach before beginning care.

Interview with the facility DON on 3/15/19 at 3:00 PM revealed during the resident's multiple years of residency she had sustained only one other fall other than the ones sustained on 12/10/18 and 3/4/19. The DON stated that prior to 12/10/18, there had been an incident on which the resident was found half on and half off the bed on 10/19/18, and therefore she could move her body

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some. The DON felt the 12/10/18 incident was very isolated, and he had not conducted widespread in-service training with all of his staff at that point. After the 3-4-19 incident he evaluated the need to in-service his staff in the following areas and developed a plan of correction in regards to making sure the following measures were followed: If a resident sustained a fall, then they would automatically be made a two person transfer; Nurses would be responsible for writing an order, and the MDS nurse would update the care plan to reflect the need for a two person assistance; Staff were to monitor the FYI sheets daily to know the correct transfer status and mobility status of residents; If staff felt unsafe while caring for residents, they were to obtain help; Staff were trained to pull a resident close to them before turning a resident; Staff were trained to have all their supplies with them before starting care. According to the DON, he had not completely finished his in-service training of all his staff and he had not yet begun any audits.

2. Record review revealed Resident # 3 was admitted to the facility on 4/18/18. The resident had diagnoses of Stage 4 chronic kidney disease and heart failure.

Review of Resident # 3's quarterly MDS (Minimum Data Set) assessment, dated 1/2/19, revealed the resident was coded as cognitively intact, incontinent of bowel and bladder, and needed extensive assistance by two staff members with her bed mobility. The resident was assessed to need extensive assistance of one staff member with hygiene needs.

Review of Resident # 3's care plan, last revised on 2/12/19, revealed the resident was identified to

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	345175	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR NURSING AND REHAB	902 BERKSHIRE ROAD SMITHFIELD, NC 27577

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be at risk for falls due to a history of fall. According to the 2/12/19 care plan, this problem had been added to the care plan on 8/3/18. One of the interventions on the care plan which had been initiated on 8/20/18 and remained in effect through 2/12/19 was to provide two person assistance with all activities of daily living.

Review of nursing notes revealed an entry by Nurse # 2 on 1/23/19 at 9:38 PM noting the following. The resident's brief was being changed, and when she was turned over, she had involuntary jumping movements and slid off the bed landing on buttocks. Her left great toenail was bleeding and loose up to the nailbed. The toe was wrapped.

Resident # 3 was interviewed on 3/15/19 at 9:03 AM and reported the following. There was only one Nurse Aide (NA) who was assisting her on 1/23/19 when the incident occurred. The resident stated she needed two people to assist her. The resident stated she told the NA, "Don't push too hard because I'm going to roll out of the bed" while the NA was changing her brief. The resident stated the NA replied to her that she was not going to roll off the bed because she had her. The resident stated while the care was being provided, she then rolled out of the bed and onto the floor. The resident stated her big toenail came off because of the fall.

NA # 3 was interviewed on 3/15/19 at 11:40 AM and reported the following. NA # 3 was Resident # 3's NA on the evening of 1/23/19. She was aware the resident needed two people to turn and reposition, but at the time of the incident the resident was soiled. NA # 3 reported she could not find another staff member at the time, and

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therefore she thought it was more important to make sure the resident was not lying soiled in bed. She therefore did the care alone. NA # 3 reported the resident always stated she was going to fall when she was turned, and this was a routine statement for her. When she turned her for the care, the resident's legs jerked and NA # 3 reported she could just not grab her in time to stop her from rolling out of the bed.

Nurse # 2 was interviewed on 3/15/19 at 12:46 PM. Nurse # 2 reported she was the nursing supervisor on the evening of 1/23/19, and had been called into Resident # 3's room where she found her on the floor. She had talked to NA # 3 who had informed her that one part of the resident's body jerked and came off the bed, and then the rest of her body started rolling. The nurse stated the resident's toenail was lifted up, but otherwise the resident was without injury.

Interview with the DON (Director of Nursing) revealed NA # 3 was a newer NA at the time, and she had not followed the resident's plan of care on 1/23/19 when she did not get help to turn Resident # 3. The DON stated he had taken measures for individualized counseling and follow up with her regarding safety at the time, but had not implemented full in-services with all of his staff following the incident until another resident rolled out of bed while a staff member was in attendance on 3/4/19. According to the DON, in-service training began on 3/4/19 regarding safety measures and was on-going.