

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

PRINTED: 06/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2013
NAME OF PROVIDER OR SUPPLIER WESTCHESTER MANOR AT PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	
(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 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, resident and responsible party interviews the facility failed to determine the cause of falls, to implement the bed alarm and evaluate interventions to prevent further falls 1 of 6 residents reviewed with falls. (Resident #5)</p> <p>Findings included:</p> <p>Review of the electronic record revealed Resident #5 was admitted on 5/01/13 at 4:06 PM, for rehabilitation. His diagnoses were in part, incomplete left hip and a rib fracture, diabetes mellitus, chronic kidney disease, atrial fibrillation and dementia. He was readmitted from the hospital on 5/15/13 due to gastrointestinal bleeding.</p> <p>Review of the care plan for falls dated 5/10/13 revealed in part the facility was to investigate the cause of fall immediately, and evaluate the pattern of falls if resident fell more than once. Anticipate Resident #5 needs in relation to present ADL 's (activity of daily function).</p>	F 323	<p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907 _____</p> <p>F323</p> <p>1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Facility completed post fall investigation in regards to Resident #5 and the event of 6/3/13. Care plan interventions for resident #5 were evaluated by the interdisciplinary team for appropriateness. Interventions were implemented on 6/4/13 which included a physical evaluation, an order for an x-ray, therapy referral and initiation of a prompted toileting program. Bed alarm intervention continued. Results of x-ray and evaluation were called and faxed to physician on 6/4/13. Nurse Practitioner evaluated resident #5 on 6/5/13 with no new orders given.</p>	6/14/13

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

TITLE

(X6) DATE

James R. Newman, Jr.

Administrator

6/21/13

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>Review of the discharge summary dated 5/15/13 revealed due to a fall risk, Coumadin (a blood thinning agent) 2 mg (milligram) a day by mouth except Tuesday and 1 mg on Tuesday was discontinued and aspirin 81 mg every day was started.</p> <p>Review of the fall risk assessment dated 5/15/13 indicated Resident #5 was at high risk for falls.</p> <p>The amended care plan on 5/17/13 included the addition of a sensor pad alarm to wheelchair and bed, nursing to check placement and functioning every shift and a floor matt at the bedside.</p> <p>Review view of the Accident Report dated 5/20/13 revealed Resident #5 had an unwitnessed fall on 7:00 AM. No injury was sustained. No further interventions were implemented.</p> <p>The Minimum Data Set dated 5/29/13, revealed cognition was intact and he was able to make decisions of his daily care. He required extensive assistance with two people to perform bed mobility, to transfer, to use the toilet, to dress and for personal hygiene. He was totally dependent on staff for bathing. He was not steady and only able to stabilize with staff assistance when moving on and off the toilet, turning around, walking moving from a seated to a standing position and surface to surface transfer. He had left lower extremity impairment, requiring a walker or wheelchair. Resident #5 was frequently incontinent of bowel or bladder, and currently was not managed on toileting program.</p> <p>Review of current physician order dated 6/1/13</p>	F 323	<p>2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p>An audit of falls risk assessments was completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, Rehab Staff and Social Worker for all residents to ensure appropriate interventions are in place with revision of care plan as necessary on 6/11/13. An audit of all resident care plans related to falls was completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, Rehab Staff and Social Worker on 6/11/13 to review fall interventions and goals. An audit of all residents utilizing bed alarms was completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, Rehab Staff and Social Worker on 6/11/13 to ensure alarms in place and functioning appropriately. These audits consisted of a review of each residents fall risk assessment, a</p>		

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F 323	<p>Continued From page 2</p> <p>revealed Lasix (a diuretic) 0.5 mg by mouth daily.</p> <p>Review of the nursing note dated 6/3/13 at 4:50 AM, Nurse #1 revealed " Resident got up and went to the bathroom. On his way back when he got to his bed as he reached for the bed he stated he lost his balance and dropped to his knees on the safety matt at his bedside. No injury noted. Vital signs stable. Will continue to monitor. "</p> <p>During an interview on 6/4/13 at 11:44 am the DON (Director of Nursing) indicated Resident #5 had not sustained a fall on 6/3/13, there was no documented accident report or SBAR (Situation, Background, Assessment and Recommendation). The DON was then asked to read the nurses noted dated 6/3/13 at 4:50 am. She had no further comment.</p> <p>During an interview on 6/4/13 at 2:25 PM, Nurse #1 indicated no assessment was done to determine the caused the fall and no new interventions were put into place.</p> <p>During an interview via telephone on 6/6/13 at 11:27 AM, Aide #1 indicated Resident #5 yelled (a name) when he needed toileting or he got up and the alarm would sound. She heard the alarm sounding on 6/4/13 and assisted Nurse #1 to get Resident #5 in bed. She had asked him if he needed to be toileted and he said. " No. " She indicated she checks on him at least every two hours.</p> <p>During an interview on 6/4/13 at 1:43 pm, while with the RP (responsible party) and another family member present, Resident #5 indicated he did not remember a fall yesterday. Observation</p>	F 323	<p>review of the resident care plan for appropriate interventions and a review of progress notes for documentation of compliance with interventions. Nurses are documenting placement and function of alarms each shift.</p> <p>3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:</p> <p>Nurses educated as to procedure for shift change reporting by Staff Development Coordinator. Training will be completed on 6/14/13.</p> <p>Nurses conducting a shift to shift review of progress notes to monitor resident change of condition or other resident events. Nurse management to conduct a 24 hour review of all progress notes, accident/incident reports with review of SBAR's . Licensed and certified staff will be educated in regards to necessity, placement and proper functioning of safety devices with completion on 6/14/13.</p>	
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F 323	<p>Continued From page 3</p> <p>revealed Resident #5 sitting in bed without an alarm device. The alarm was attached to the head board behind the bed, out of sight. There was no alarm pad on the bed. When asked how Resident #5 got into bed. The family member indicated he stood up and got into bed himself. A family member indicated Nurse #2 was just in the room and assessed Resident #5 for bruising and pain because he fell the day before. The RP rang the call bell for staff to attach the bed alarm. The RP indicated they had been unsuccessful to get Resident #5 to use the call bell. " We have talked and talked to him, he just doesn ' t use it. "</p> <p>During an interview on 6/4/13 at 2:08 PM, Aide #2 indicated the alarm should be connected. She demonstrated the alarm operation pulled it apart to cause it to sound and placed it on Resident #5. During an interview on 6/4/13 at 2:11 PM, Aide #3 indicated Aide #4 had put Resident #5 to bed after lunch and did not put the alarm on him. During an interview on 6/4/13 at 2:15 PM Aide #4 indicated she had not assisted Resident #5. During an interview on 6/4/13 at 2:19 PM Nurse # 2 indicated the family was in the room and the alarm wasn ' t necessary.</p> <p>During an interview on 6/4/13at 5:00 PM the DON indicated the SBAR and accident reports are reviewed every morning, to determine the cause of a fall and put interventions into place.</p>	F 323	<p>4. Indicate how the facility will monitor its performance:</p> <p>Director of Nursing or Assistant Director of Nursing will review all progress notes daily for four weeks. Director of Nursing or Assistant Director of Nursing will conduct an audit of 50% of residents utilizing bed alarms for appropriateness, placement and proper functioning. Interdisciplinary team review of all resident events conducted daily. Results will be presented to the Quality Assurance team for recommendations and follow up for 6 months.</p>	
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