STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0550	A. BUILDING: _____ B. WING _____	C 04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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) COMPLETE DATE
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on record review and staff and family interview, the facility failed to notify the resident's responsible party when a resident was transferred to a hospital for 1 (Resident #1) of 3 sampled residents reviewed for notification. Findings included: The facility's policy and procedure in transferring a resident to a hospital dated 11/30/14 was reviewed. The policy under the procedure read in part " notify the family or responsible party of the	D 454	1. Resident #1 no longer resides in the facility. 2. All residents residing in the facility have a potential to be affected. On 5/2/16 The Director of Clinical Services/Unit Manager reviewed the 24 Hour Reports for 30 days for any resident transfers noted to ensure the family has been notified. 3. The Director of Clinical Services	5/10/16

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D 454	Continued From page 1 pending transfer and the reason for the move. " Resident #1 was admitted to the facility on 5/10/13 with multiple diagnoses including Congestive Heart Failure, Status post liver transplant, Viral Hepatitis C, Bipolar Disorder and Chronic Kidney Disease, stage IV. The facility's accident/incident log was reviewed. Resident #1 had one incident/accident dated 4/9/16. The incident/accident report indicated that the resident had a fall which resulted in a laceration above his right eye. The nurse's notes dated 4/9/16 at 11:00 AM revealed that Resident #1 was observed lying on his back between the bed and the bedside table. Bleeding to his right eye was noted. He was alert and oriented x (times) 4. Neuro check was initiated, head to toe body check was done and the laceration (1 centimeter long) was cleaned and steri - strips applied. The nurse's s notes dated 4/10/16 (11-7 shift) indicated that Resident #1 was alert and verbal. He had no complaints voiced and no apparent distress/discomfort. Neuro check was within normal limits. The notes further indicated that the resident later complained of weakness. A staff member had to assist him with transfer and activities of daily living (ADL). The doctor's progress notes dated 4/11/16 was reviewed. The notes indicated that Resident #1 had a fall on 4/9/16. He hit his head and obtained a laceration to right lateral eyebrow. Since the fall, the resident had become weaker and his mentation had been altered and sluggish and his speech was slurred. He could barely sit up in bed this morning. Will send to the emergency room for further evaluation. The nurse's notes dated 4/11/16 at 11:50 AM revealed that the doctor had ordered to send the resident to the emergency room for evaluation	D 454	reeducated nursing staff currently employed, including weekend and PRN staff, by 5/10/16 on the importance of notifying the family of any resident that is transferred to the hospital according to state regulation. Nursing staff who has not received the education by 5/10/16 will not be able to work until he/she has completed this education. The Director of Clinical Services will review the 24 hr report and the resident record to ensure that resident family is notified of transfers according to state regulation. 4. The Director of Clinical Services/Unit Manager will review the records of any resident transferred to the hospital weekly for 6 weeks, and document this review on a quality improvement monitoring form. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly times 2 months for continued substantial compliance and/or revision.	

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D 454	Continued From page 2	D 454		

due to mental status changes since the fall on 4/9/16.
The nurse's notes did not indicate that the resident's responsible party was informed of the resident's transfer to the emergency room.
On 4/14/16 at 3:30 PM, Nurse #1 was interviewed. Nurse #1 stated that she was the nurse who had sent Resident #1 to the hospital. The nurse indicated that on 4/11/16 during her shift (7-3), the resident had a change in condition. He was lethargic and his speech was not normal. The Nurse Practitioner (NP) was in the building at that time and saw the resident. The NP had ordered to send the resident to the hospital for evaluation. Nurse #1 further stated that she forgot to call the responsible party that the resident was sent to the hospital.
On 4/14/16 at 9:15 AM, the family member of Resident #1 was interviewed. The family member indicated that he was not informed by the facility that the resident was sent to the hospital on 4/11/16. The family member stated that he received a call from the hospital around 8:20 PM of 4/11/16 asking information about the resident.
On 4/14/16 at 4:32 PM, the administrator was interviewed. The administrator indicated that he expected the staff to inform the responsible party of the resident when a resident was transferred to a hospital or emergency room.
On 4/14/16 at 4:33 PM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the nurse to call the resident's responsible party when a resident was transferred to a hospital/emergency room. She further indicated that she had educated the nurse of the importance of communicating with the family when a resident was transferred to the hospital.