STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	C 04/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to follow the plan of care for 1 of 3 sampled resident ' s (Resident #1) who was care planned for a geri-chair and a chair alarm for risk for falls. Findings included: Resident #1 was admitted to the facility on 2/19/16 with the diagnosis of left femur fracture, chronic obstructive pulmonary disease and dementia. Resident #1 was discharged home on 3/22/16. The most recent Minimum Data Set (MDS) assessment with assessment reference date of 3/18/16 revealed that Resident #1 was severely cognitively impaired and required extensive assistance with activity of daily living (ADL ' s) to include bed mobility and transfers. The care plan initiated on 3/1/16 with a focus on mobility indicated that Resident #1 required assistance for mobility related to left hip fracture with an intervention that indicated dependent in geri-chair. A focus on 3/1/16 for risk for falls related to impaired balance revealed interventions to keep resident in areas of high traffic when in geri-chair and when family is not	F 282	Piney Grove 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. The Plan of Correction is submitted as a written allegation of compliance. Piney Grove 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, Piney Grove 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. On 3/21/2016, Resident #1 was immediately assessed by a nurse. After the assessment, Resident #1's physician was notified and neurological checks were	4/28/16

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

Electronically Signed | 04/20/2016

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F 282	Continued From page 1 with her and provide personal alarm: bed and chair. The resident care guide for nurse aide ' s dated 3/1/16 for Resident#1 listed interventions of non-ambulatory, aide of 2 persons, keep resident in areas of high traffic when in geri-chair and family is not with her, assist with eating, falls, non-kid foot wear, keep personal items within reach, hi-low bed: return to lowest position when giving care, mat on floor beside of bed, toilet frequently, alarm: bed and chair, geri-chair, dentures(upper). Review of the incident note written by nurse #1 dated 3/21/16 at 7:50 AM revealed in part: the nurse aide observed resident #1 attempting to leave the dining room and tried to roll wheel chair out while sitting in it, the chair was locked and the chair flipped back. Resident #1 fell and hit her head, resident was assessed by a nurse and it was reported to nurse #1 that resident had a knot on the back of her head, nurse #1 assessed Resident #1 ' s head and noted the same finding, the medical doctor was informed and new order was received for neruo checks every 4 hours, vital signs were blood pressure- 132/88, pulse 120, respirations 16, temperature 98.9, pulse was rechecked and decreased to 98 and resident ' s daughter was notified. A physicians order was obtained on 3/21/16 at 10:03 AM to transfer resident to the hospital for further evaluation after hitting head with fall. The computerized tomography (CT) scan of brain without contrast dated 3/21/16 revealed impression of no acute intracranial abnormality.	F 282	initiated with no negative findings. on 3/21/2016, Resident #1's responsible party was notified. On 3/21/2016, Resident #1 was sent to the hospital for further evaluation. On 3/21/2016 Resident #1 returned from the hospital after a computerized tomography scan of the brain was completed revealing no acute intracranial abnormality. On 3/22/2016, the director of nursing, QI nurse, and staff facilitator completed a 100% in-service with all nursing assistants and nurses regarding following the resident care plan and resident care guide to include using the proper chair for residents. On 4/4/2016, the director of nursing, QI nurse, and staff nurse completed a 100% audit to ensure all residents, including Resident #1, were with the appropriate chair and/or safety alarms. The audit revealed all residents were in the appropriate chair, as assigned in the resident care plan and on the resident care guide. Any alarms that were not properly placed on the resident's chair or bed were immediately placed correctly. On 4/4/2016, the director of nursing, QI nurse, and staff nurse initiated an in-service related to chair or bed alarms being appropriately placed and functioning properly with all nursing assistants and nurses. This was 100% completed on 4/7/16. On 4/20/2016, the director of nursing, QI	

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F 282	Continued From page 2 An interview with nurse #1 on 4/2/16 at 8:45 AM revealed that she was on duty on 3/21/16 and was called to the dining room and assessed Resident #1 when she fell. She indicated that Resident #1 had tipped over her wheelchair. Nurse #1 further indicated that she was not familiar with Resident #1 and did not know if she was suppose to be in a wheelchair or a geri-chair and was not aware if a chair alarm should be in place. Nurse # 1 stated the nurse aides have a care guide in the resident ' s closet to let them know their care needs. An interview with nurse aide #1 on 4/2/16 at 10:30 AM indicated that she was assigned to Resident #1 on 3/21/16 and observed Resident #1 push the dining room table, the wheel chair was locked and the wheel chair tipped backwards, she went towards her to stop the fall but it was too late. The wheel chair did not have a chair alarm in place. Nurse aide #1 revealed that the geri-chair was not in her room and could not be located for a few days and Resident #1 was placed in the wheelchair and there were no chair alarm in the wheelchair, the chair alarm was in the geri-chair. During a phone interview with nurse aide #2 on 4/2/16 at 10:40 AM revealed that she was in the dining room and observed Resident #1 push the wheelchair away from the table, the wheelchair was locked and the wheelchair fell backwards. She indicated that Resident #1 was not in a geri-chair and there were no chair alarm in place. An interview with the director of nurses on 4/2/16 at 11:08 AM revealed that she would expect Resident #1 to be in the safest device, Resident#1 was in the process of being evaluated	F 282	nurse, MDS nurse, staff facilitator, and staff nurse began auditing all resident care guides to ensure bed and/or chair alarms are properly noted on the resident care guide, resident care plan, and are properly placed and working. This audit will be completed 5 days per week for one week, then 3 days per week for 4 weeks, then 1 time weekly for 8 weeks. On 4/20/2016, the director of nursing, QI nurse, MDS nurse, staff facilitator, and staff nurse began auditing nursing assistants and nurses to ensure the nursing assistants and nurses are following the care guide and care plan, to include assisting the resident into the correct assigned chair and with assigned alarm. This audit will be documented on Resident Care Audit form. These audits will be completed 5 days per week for one week, then 3 days per week for 4 weeks, then 1 time weekly for 8 weeks. On 4/20/2016, the director of nursing or QI nurse will begin reporting the results of the audits to the monthly QI committee. The monthly QI committee will review the results of the audits and make recommendations as needed for continued compliance in this area, and to determine the need for and/or frequency of continued QI committee monitoring.	

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F 282	Continued From page 3 for a wheelchair but expects the staff to use the care guide and care plan and follow it until it is changed.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to implement care plan interventions for a geri-chair and chair alarm for 1 of 3 sampled residents reviewed for falls (Resident #1). Findings included: Resident #1 was admitted to the facility on 2/19/16 with the diagnosis of left femur fracture, chronic obstructive pulmonary disease and dementia. Resident #1 was discharged home on 3/22/16. The most recent Minimum Data Set (MDS) assessment with assessment reference date of 3/18/16 revealed that Resident #1 was severely cognitively impaired and required extensive assistance with activity of daily living (ADL ' s) to include bed mobility and transfers. Resident #1 ' s balance was assessed to be not steady and only	F 323	On 3/21/2016, Resident #1 was immediately assessed by a nurse. After the assessment, Resident #1's physician was notified and neurological checks were initiated with no negative findings. on 3/21/2016, Resident #1's responsible party was notified. On 3/21/2016, Resident #1 was sent to the hospital for further evaluation. On 3/21/2016 Resident #1 returned from the hospital after a computerized tomography scan of the brain was completed revealing no acute intracranial abnormality. On 3/22/16, the director of nursing, QI nurse, and staff facilitator completed a 100% in-service with all nursing assistants and nurses regarding following the resident care plan and resident care guide to include using the proper chair for	4/28/16

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F 323	Continued From page 4 able to stabilize with staff assistance and a high risk for falls. The care plan initiated on 3/1/16 with a focus on mobility indicated that Resident #1 required assistance for mobility related to left hip fracture with an intervention that indicated dependent in geri-chair. A focus on 3/1/16 for risk for falls related to impaired balance revealed interventions to keep resident in areas of high traffic when in geri-chair and when family is not with her and provide personal alarm: bed and chair. The resident care guide for nurse aide ' s dated 3/1/16 for Resident#1 listed interventions of non-ambulatory, aide of 2 persons, keep resident in areas of high traffic when in geri-chair and family is not with her, assist with eating, falls, non-kid foot wear, keep personal items within reach, hi-low bed: return to lowest position when giving care, mat on floor beside of bed, toilet frequently, alarm: bed and chair, geri-chair, dentures(upper). Review of the incident note written by nurse #1 dated 3/21/16 at 7:50 AM revealed in part: the nurse aide observed resident #1 attempting to leave the dining room and tried to roll wheel chair out while sitting in it, the chair was locked and the chair flipped back. Resident #1 fell and hit her head, resident was assessed by a nurse and it was reported to nurse #1 that resident had a knot on the back of her head, nurse #1 assessed Resident #1 ' s head and noted the same finding, the medical doctor was informed and new order was received for neruo checks every 4 hours, vital signs were blood pressure- 132/88, pulse 120, respirations 16, temperature 98.9, pulse was	F 323	residents. On 4/4/2016, the director of nursing, QI nurse, and staff nurse completed a 100% audit to ensure all residents, including Resident #1, were with the appropriate chair and/or safety alarms. The audit revealed all residents were in the appropriate chair, as assigned in the resident care plan and on the resident care guide. Any alarms that were not properly placed on the resident's chair or bed were immediately placed correctly. On 4/4/2016, the director of nursing, QI nurse, and staff nurse initiated an in-service with all nursing assistants and nurses related to chair/bed alarms being properly placed and operating. This was 100% completed on 4/7/16. On 4/20/2016, the administrator,the director of nursing, QI nurse, MDS nurse, staff facilitator, and staff nurse began auditing using the Hazard/Supervision/Devices audit tool to monitor residents in dining room, activities, hallways, shower rooms and resident rooms to ensure the residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. On 4/20/2016, the director of nursing, QI nurse, MDS nurse, staff facilitator, and staff nurse began auditing all resident care guides to ensure bed and/or chair alarms are properly noted on the resident	

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F 323	Continued From page 5	F 323		

rechecked and decreased to 98 and resident ' s daughter was notified.

A physicians order was obtained on 3/21/16 at 10:03 AM to transfer resident to the hospital for further evaluation after hitting head with fall.

The computerized tomography (CT) scan of brain without contrast dated 3/21/16 revealed impression of no acute intracranial abnormality.

An interview with nurse #1 on 4/2/16 at 8:45 AM revealed that she was on duty on 3/21/16 and was called to the dining room and assessed Resident #1 when she fell. She indicated that Resident #1 had tipped over her wheelchair. Nurse #1 further indicated that she was not familiar with Resident #1 and did not know if she was suppose to be in a wheelchair or a geri-chair and was not aware if a chair alarm should be in place. Nurse # 1 stated the nurse aides have a care guide in the resident ' s closet to let them know their care needs.

An interview with nurse aide #1 on 4/2/16 at 10:30 AM indicated that she was assigned to Resident #1 on 3/21/16 and observed Resident #1 push the dining room table, the wheel chair was locked and the wheel chair tipped backwards, she went towards her to stop the fall but it was too late. The wheel chair did not have a chair alarm in place. Nurse aide #1 revealed that the geri-chair was not in her room and could not be located for a few days and Resident #1 was placed in the wheelchair and there were no chair alarm in the wheelchair, the chair alarm was in the geri-chair.

During a phone interview with nurse aide #2 on

care guide, resident care plan, and are properly placed and working. This Hazards/Supervision/Devices audit tool will be completed 5 days per week for one week, then 3 days per week for 4 weeks, then 1 time weekly for 8 weeks.

On 4/20/2016, the director of nursing or QI nurse will begin reporting the results of the audits to the monthly QI committee. The monthly QI committee will review the results of the audits and make recommendations as needed for continued compliance in this area, and to determine the need for and/or frequency of continued QI committee monitoring.

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F 323	Continued From page 6 4/2/16 at 10:40 AM revealed that she was in the dining room and observed Resident #1 push the wheelchair away from the table, the wheelchair was locked and the wheelchair fell backwards. She indicated that Resident #1 was not in a geri-chair and there were no chair alarm in place. An interview with the director of nurses on 4/2/16 at 11:08 AM revealed that she would expect Resident #1 to be in the safest device, Resident#1 was in the process of being evaluated for a wheelchair but expects the staff to use the care guide and care plan and follow it until it is changed.	F 323		