

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/17/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE LAURELS OF CHATHAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312</b>
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F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 observation, record review, and resident and staff interviews, a nurse aide failed to provide adequate supervision during the provision of a bed bath to a resident with balance and mobility limitations for 1 (Resident # 1) of 3 sampled residents reviewed for accidents. The findings included:</p> <p>Record review revealed Resident # 1 was admitted to the facility on 12/6/18 and had experienced two prior strokes which limited his ability to independently balance himself.</p> <p>Record review revealed on 12/6/18 an admission fall risk assessment was completed, and the resident was assessed to be high risk for falls.</p> <p>Review of Resident # 1's baseline care plan, dated 12/6/18, revealed the resident was identified to be at risk for falls. One of the interventions was to instruct the resident regarding safety measures to prevent falls.</p> <p>Review of a physical therapy evaluation, dated 12/7/18, revealed under left extremity muscle tone, the therapist had noted, "Flaccid on L (left)." Review of a OT (occupational therapy)</p>	F 689	<p>The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is 1-25-2019. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.</p> <p>F 689 Corrective Action</p> <p>Resident #1's care card has been updated to reflect his fall risk and to reflect history and dates of falls.</p> <p>Corrective action for those who have the potential to be affected</p> <p>At the time of survey, all care cards were reviewed by the Director of Nurses and the unit managers. The cards were</p>	1/25/19
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  01/24/2019
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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	<p>Continued From page 1</p> <p>evaluation, dated 12/7/18, revealed the OT noted the resident's left upper extremity muscle tone was flaccid, and he had "L paresis" (left weakness) in his fine motor coordination (small muscle movements).</p> <p>Record review revealed the resident's admission minimum data set (MDS) assessment, dated 12/13/18, coded the resident with a BIMS (Brief Interview for Mental Status) of a 13. This indicated the resident was cognitively intact. The resident was assessed not to have a history of falls. The resident was assessed to need extensive assistance with his hygiene needs, bed mobility, and transfers. He was also assessed to have problems with balance and range of motion.</p> <p>Review of occupational therapy documentation revealed Resident # 1's "dynamic sitting" balance was assessed to be "fair minus" on 12/21/18. The resident was also assessed on this date by OT to need fall risk precautions because of his left hemiparesis and impulsivity.</p> <p>Interview with the rehab director on 1/16/19 at 12:30 PM revealed a dynamic sitting balance score of "fair minus" generally indicated a resident needed minimum staff assistance to maintain their balance if making movements. According to the rehab director, minimum assistance would indicate the staff member was still offering some physical help to a resident to maintain their balance. The rehab director stated the resident's impulsivity in his movements was a result of the type of stroke he had suffered.</p> <p>Record review revealed Resident # 1 sustained an unwitnessed fall on 12/23/18 at 2 PM. Review of the facility's investigation into the 12/23/18</p>	F 689	<p>reviewed for the most recent quarterly fall risk assessment that noted medium to high risk for falls to ensure the fall risk was noted on the care card. No other care card was found to be affected by this alleged deficient practice.</p> <p>Systemic changes</p> <p>All care cards will be brought to the daily clinical ops meeting, reviewed by the interdisciplinary team, and will be updated by the unit manager and/or MDS Care Plan Nurse, for any falls and/or change in fall risk. All licensed staff has been in-serviced by the Staff Development Coordinator, to include information on the care card regarding history of falls and fall risk.</p> <p>Monitoring</p> <p>The Director of Nurses, using a QA auditing tool, will review all care cards, weekly for the next 2 months, and then will review random care cards weekly for the next two months to ensure that any and all falls are available for the aide to review, as well as the fall risk. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.</p>		

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F 689	<p>Continued From page 2</p> <p>incident, dated 12/24/18, revealed the resident told the staff he had "slid out of his wheelchair." Corrective measure on the facility's investigation report included a referral to therapy services for anti-rollbacks for the resident's wheelchair.</p> <p>Interview with Nurse # 1 on 1/16/19 at 3:25 PM revealed she had been assigned to Resident # 1 on 12/23/18. The nurse stated Resident # 1 was assessed for injury following the fall, and found to have no injury.</p> <p>Record review revealed Resident # 1 sustained a second unwitnessed fall on 12/27/18 at 2:55 PM. The resident was found in his room on the floor. Review of the facility's investigation into the 12/27/18 incident, dated 12/27/18, revealed the resident told the staff he had "slid out of his wheelchair." The investigation noted the family had provided a personal cushion for the resident to sit on, and it had slid out of the wheelchair along with the resident. Corrective measure on the facility's investigation report included a referral to therapy services for a proper cushion.</p> <p>Interview with Nurse # 2 on 1/16/19 at 3:10 PM revealed she had been the nurse, who had been assigned to care for Resident # 1 on 12/27/18. The nurse stated the resident was not hurt, and following the incident therapy provided the resident with a wedge cushion to prevent him from sliding out of his chair.</p> <p>Review of the resident's comprehensive care plan, dated 12/28/18, revealed the staff identified the resident was at risk for falls. Although not all inclusive some interventions were to observe the resident for fatigue and or/unsteadiness and for the resident to receive therapy services.</p>	F 689			

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F 689	<p>Continued From page 3</p> <p>Record review revealed Resident # 1 sustained a third fall on 1/2/19 at 9:22 AM. Nurse # 3 documented in a nursing entry, the resident had fallen from his bed and hit his head. The resident was assessed by the nurse to have stable vital signs and reactive pupils. The resident's RP (responsible party) was notified, and the resident was sent to the emergency room for an evaluation.</p> <p>On 1/2/19 at 2:41 PM, Nurse # 3 documented the resident returned from the emergency room with no new orders.</p> <p>Resident # 1 was interviewed on 1/16/19 at 8:55 AM and again on 1/16/19 at 2:10 PM. The resident reported the following details in regards to the fall of 1/2/19. The NA (nurse aide) had assisted him to sit up on the side of the bed for his bath. She had the bedside table behind her, and turned to reach for something. When she turned he slid out of the bed and hit his head. The resident was consistent in reporting how the fall occurred in both interviews. During the interview, which was conducted on 1/16/19 at 2:10 PM, Resident # 1 was interviewed regarding whether he had any movement in his left side. The resident indicated he had some, and tried to move his left arm and left leg. There was no movement observed in his left arm or left leg on 1/16/19 at 2:10 PM when the resident tried to initiate movement.</p> <p>An interview was conducted with NA (Nurse Aide) # 1 on 1/16/19 at 1:15 PM. NA # 1 confirmed she had been the NA who had assisted Resident # 1 with his bath on 1/2/19 when he fell. NA # 1 reported the following. Prior to the incident date</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>she had cared for Resident # 1 about three times, and did not routinely care for him. Prior to Resident # 1's care on 1/2/18, she had inquired of a rehab staff member or a nurse if he could sit up on the side of the bed for his bath. She recalled being told, "yes." The NA could not recall the specific staff person to whom she had spoken. She did not recall being instructed regarding any precautions she was to take with the resident. She set the resident's bath basin on the table beside the bed. She then assisted the resident to sit up on the side of the bed. At that point the bedside table was right behind her at the bedside. She turned sideways to the resident in order to pull the table closer to her. She could still see the resident as she pulled the bedside table closer. As she was pulling the table closer, she could see the resident start to fall over to the floor. The NA reported if she could have been about "five inches" closer, then she felt she could have caught him. The NA reported she had not been instructed that the resident had a balance problem, that he was impulsive, or that he had fallen two other times before 1/2/19. According to the NA, she would have assisted the resident with his bath in the bed and not on the bedside if she had known these things. She stated there is usually a care guide for the NAs to review and which is located on the interior door of every resident's closet. The NA stated she had looked at the care guide prior to caring for the resident. The NA could not recall exactly what was on the care guide; only that she had looked at it.</p> <p>On 1/16/19 at 3:30 PM the OTA (Occupation Therapy Assistant), who routinely worked with Resident # 1, was interviewed. The OTA stated she had been working with the resident on sitting balance prior to the incident, and she did not</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>recall giving any instruction to the nursing staff before 1/2/19 that the resident was safe to sit at bedside for his ADLs (activities of daily living). The OTA stated she had questioned the resident on 1/3/19 regarding the fall, and the resident had said his feet were not all the way on the floor when he slid off the bed.</p> <p>Interview with the rehab director on 1/17/19 at 10:45 AM revealed she had spoken to all her rehab staff members, and verified that no one had given nursing staff directions that the resident was safe to sit up at bedside for his bath.</p> <p>Interview with NA # 2 on 1/17/19 at 1:05 PM revealed NA # 2 routinely cared for Resident # 1 during the dayshift. NA # 2 stated she assisted Resident # 1 with his bath in the bed. NA # 2 stated the resident leaned, and she did not think it was safe to sit him at bedside for his bath.</p> <p>Resident # 1's Unit Nurse and the DON (Director of Nursing) were interviewed on 1/17/19 at 10:00 AM. They provided a copy of the resident's "nursing care card" which was dated 12/6/18 and a copy of the updated "nursing care card" dated 1/9/19. The Unit Nurse stated a copy of the nursing care card was placed in the interior door of the resident's closet and at the desk, and was based on the resident's care plan. Review of the 12/6/18 care card revealed a section entitled "Fall Risk." The entire section was blank, and it did not note that the resident was at risk for falls. The nursing care card, dated 1/9/19, revealed an update had been made to reflect Resident # 1 was at risk for falls and that he was not to be left unattended at bedside. The Unit Nurse and the DON stated nursing care cards were periodically updated to reflect information NAs needed to</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>know for resident care. They could not verify when Resident # 1's nursing care card had been updated from the 12/6/18 card, which noted no fall precautions, to the one on 1/9/19 noting the resident was at risk for falls. According to the DON, she had investigated the resident's fall of 1/2/19, and had been told during the investigation that rehab had deemed the resident to be safe to sit on the bedside.</p> <p>The resident's physician was interviewed on 1/17/19 at 12:35 PM. According to the physician the resident had sustained a bump to the head, which was assessed in the hospital, and found to be "nothing serious." According to the physician there had been no treatment change due to the incident, and the resident was stable following the incident</p>	F 689			