STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495332	A. BUILDING _____ B. WING _____	C 09/07/2017

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RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD	101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430

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F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 9/6/17 through 9/7/17. One complaint was investigated. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 34 certified bed facility was 29 at the time of the survey. The survey sample consisted of 14 residents, 10 current Resident reviews (Resident #1 through #9) and 5 closed record reviews (Resident #10 through #14).	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		9/14/17

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

Electronically Signed | 09/14/2017

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F 323	Continued From page 1 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, clinical record review and facility document review the facility staff failed to implement fall interventions consistent with the resident's needs and plan of care to reduce the risk of an avoidable accident for 1 of 14 residents in the survey sample, Resident #3, that resulted in a fall with subsequent fracture requiring surgical intervention. Resident #3 was identified as requiring two staff for positioning, two staff for safe transfers and the use of a total body lift (Maxi lift) transfer device to reduce the risk of accidents. On 8/5/17 during the preparation of a transfer from the bed to a wheelchair the facility staff failed to implement the use of two persons for positioning, two staff for transfers and failed to implement the correct transfer device. As a result the resident was repositioned to sit on the edge of the bed by one staff. The certified nurse aide (CNA #1) stepped back from the resident to maneuver a sit to stand lift; not the required Maxi lift device. The resident was not physically able to maintain a sitting position on the edge of the bed and started sliding off. CNA#1 caught the resident under both arms and straddled the resident while placing the call bell on. The resident's lower body was completely off the bed. The CNA was not able to get the resident back on the edge of the bed and lowered the resident to the floor. As a result of the assisted fall Resident #3 sustained a spiral fracture to the right leg.	F 323	Past noncompliance: no plan of correction required.	

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The findings included:

Resident #3 was admitted to the facility on 12/20/12 with diagnoses to include, but not limited to, advanced dementia, history of falls and osteoporosis.

The MDS (Minimum Data Set) with an assessment reference date of 7/13/17 coded the resident as having highly impaired hearing and impaired vision. The resident scored a 5 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognition. The resident exhibited cognitive inattention. Under Functional Status activities of daily living the resident was coded as being dependent on two staff for transfers and required extensive assistance of two staff for bed mobility. Under Balance During Transitions and Walking the resident was coded as not steady, only able to stabilize with staff assistance during surface-to-surface transfer (transfer between bed and chair or wheelchair). The resident was identified with functional limitation with range of motion impairment to one upper extremity and both lower extremities.

On the Fall Risk Evaluation dated 1/11/17 the resident scored a 16; a total score of 10 or above equals high risk. On the back of this form under transfer the box was checked for two persons.

The comprehensive person centered care plan effective from 11/14/16 to 8/5/17 identified the resident was at risk for falls due to loss of balance and requirement of staff assistance for transfers. The goal was not checked. Two of the interventions to be implemented to reduce the

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resident's risk for falls included two staff for transfers and the use of a Maxi lift device. These two interventions were communicated to the staff by way of a STOP sign placed inside the resident's bathroom and listed on the Resident Profile.

The STOP sign that was current and in use at the time of the fall on 8/5/17 instructed the staff that the resident's transfer method was to use a Maxi lift, two staff with transfers and two staff for proper repositioning.

The Resident Profile available for direct care staff to include CNAs and licensed staff at the time of the fall on 8/5/17 alerted the staff that the resident was a fall risk. The resident's transfer needs of two staff with the use of a full body lift was clearly identified.

The Clinical Notes Report dated 8/5/17 read that the nurse was called into the resident's room by CNA #1. The nurse observed the resident sitting on the floor next to the bed on her bottom with her feet towards the head of the bed. The CNA stated she had helped the resident sit up on the side of the bed after she had dressed her. When she turned the resident's legs off the bed to assist the resident to get up using the lift, the resident began to slide off the edge of the mattress. At that point the CNA was not able to keep the resident on the bed and lowered the resident to the bed. The resident was assessed for pain and injury and did not exhibit any. The resident was transferred to the wheelchair using a Maxi lift and taken to the dining room for breakfast. At lunch time the resident complained of pain to the right leg. The physician was notified and an order for an X-ray was obtained.

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The X-ray dated 8/5/17 resulted in a moderately displaced fracture through the distal shift of the femur. The resident was transferred to the emergency room for evaluation.

The Hospital Discharge Summary Note evidenced the resident was admitted with a non-displaced spiral fracture of the right femur shaft (1). The resident underwent a right femur fixation surgical repair on 8/7/17 and was discharged back to the facility on 8/9/17.

On 9/6/17 at 3:45 pm, inside the resident room the resident was observed sitting up in a wheelchair. The resident's daughter and son in law were visiting and a family interview was conducted. The resident was inattentive, did not engage in the conversation, acknowledge this surveyor nor made eye contact during the interview. The daughter stated she was concerned with the resident's safety as the resident had several falls at the facility, two prior falls resulted in fractures (a refracture of the hip and a fracture of the elbow). She stated she insisted on the resident having assistance of two staff when getting up out of the bed. She stated she was told that during the last fall (8/5/17) the resident was placed on the side of the bed and slid off the bed. The lift was two feet away from the resident.

On 9/6/17 at 4:30 pm, the Nurse Mentor was interviewed about the fall. She stated this occurred on a Saturday morning. She stated the CNA (CNA #1) was labor pool. The Nurse Mentor stated the resident was sitting on the edge of the bed and began to slide off. She stated the CNA was preparing the resident for transfer using a sit

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to stand lift.

On 9/7/17 from 12:30 pm to 1:15 pm, the Director of Nursing (DON) was interviewed. The DON was asked what was the root cause of the fall based on her investigation. She stated, "She (CNA #1) did not properly prepare the resident for the appropriate transfer...she (CNA #1) should have looked at the STOP sign to be made aware of the proper method of transfer (two person assist with Maxi lift). The DON stated a QAPI (Quality Assurance Performance Improvement) Action Plan was developed in response to this fall. The DON was asked if there were any other residents who experienced a fall resulting in an injury caused by the staff failure to implement appropriate preparations or devices during transfers after the Action Plan was implemented, she stated, "No".

On 9/7/17 at 1:30 pm, CNA #2 assigned to care for Resident #3 was interviewed. She was asked how was Resident #3 supposed to be prepared for transfer prior to the fall on 8/5/17. She stated, "two person using the Maxi lift". When asked why, she stated, "Because that is what she was screened for".

A pre-exit meeting with the Administrator, the Manager of Clinical Services and the Director of Nursing was conducted on 9/7/17 at 5:30 pm. The question was asked, "Are residents sat on the edge of the bed when preparing for a total lift transfer?" The response from the Manager of Clinical Services was, "No, we already established that". When asked what led to the fall, they stated, "She (CNA #1) was attempting to transfer incorrectly."

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F 323	Continued From page 6 The QAPI Corrective Action Plan with completion date of 8/18/17 was reviewed and accepted on 9/7/17 and included: Correction: 1. The resident was assessed for correct method/assistance of transfer on stop sign and profile sheet. 2. 100% audit of all residents stop sign and residents profile sheet related to transfer. 3. Audit of residents using a sit to stand lift. 4. Re-educate nursing staff on transfers, residents profile sheets, and stop signs. 5. Nursing staff to demonstrate on the ability to operate the mechanical lifts and the ability to safely transfer. 6. Nursing staff to demonstrate the ability to read the resident stop sign and profile sheet. Other Potential: All residents are at risk that does not transfer independently. System changes: 1. Audit/Observe 2 different residents being transferred by nursing staff on each shift weekly times 3 weeks, then one resident on each shift for 3 weeks, then 2 residents monthly. Monitoring/ QA Oversight: Outcomes will be communicated in the weekly at risk meeting, re-eval referral to therapy as needed, and to QA Committee for on-going recommendations. (1.) Non-displaced spiral fracture of the right femur shaft: Femur fractures vary greatly, depending on the force that causes the break. The pieces of bone may line up correctly or be out of alignment (displaced), and the fracture may be closed (skin intact) or open (the bone has punctured the skin).	F 323		

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F 323	Continued From page 7 Spiral fracture: The fracture line encircles the shaft like the stripes on a candy cane. A twisting force to the thigh causes this type of fracture. A lower-force incident, such as a fall from standing, may cause a femoral shaft fracture in an older person who has weaker bones. http://orthoinfo.aaos.org/topic.cfm?topic=A00521 (aaos-American Association of Orthopedic Surgeons)	F 323		