

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>045222</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/21/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>WOODRUFF COUNTY HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>139 WEST HIGHWAY 64 MCCRORY, AR 72101</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0689  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Some</b>	<p><b>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Complaint # (AR 284) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure fall prevention interventions were consistently implemented to prevent further potential falls / accidents for 2 (Residents #1 and #2) of 4 (Residents #1, #2, #3, and #4) case mix residents who had falls since 7/1/2020. This failed practice had the potential to affect 2 residents who had falls since 7/1/2020, according to the list provided by the Administrator on 8/21/2020. The findings are: 1. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 6/22/2020 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); required one person assistance with transfer, locomotion on and off the unit dressing, toilet use, and personal hygiene; had two falls with no injury and one fall with injury since admission or prior assessment. a. A facility Incident and Accident Report dated 7/7/2020 at 1345 (1:45 p.m.) documented, .Res (Resident) was outside in gazebo area. Res stated he stood up and lost his balance and fell to his knees. Res was on his knees in front of his w/c (wheelchair). Res had on slides (slide-on shoes) Additional comments and / or steps taken to prevent recurrence . Res to no longer wear slides . Res to be accompanied by staff when outside . b. A facility Incident and Accident Report dated 8/10/2020 at 1443 (2:43 p.m.) documented, .Aid (Certified Nursing Assistant (CNA)) told nurse resident was in floor on call light. Resident transferring from bedside commode to bed, became dizzy and fell on back Additional comments and / or steps taken to prevent recurrence . Nonskid socks on resident and fall mat beside bed . c. The Care Plan with a revised date of 8/10/2020 documented, .7/7/2020 . outside (at) gazebo, stood up and lost his balance and fell on knees . 7/7/20 . Resident to no longer wear slides . Res to be accompanied by staff when outside . fall on 8/10/2020 . The Care Plan contained no new fall intervention for the fall on 8/10/2020. d. The physician's orders [REDACTED]. Fall mat at bedside . Check for proper placement Q (every) shift . Every shift . days, evenings, nights . e. On 8/19/2020 at 12:55 p.m., Resident #1 was not in his room. There was no fall mat in the resident's room. (The Surveyor took photographs of the resident's bedside at this time.) f. On 8/21/2020 at 10:04 a.m., Resident #1 was outside at the gazebo. The resident had slide-shoes on, and no staff was present. (The Surveyor took a photograph of the resident at this time.) g. On 8/21/2020 at 11:49 a.m., the Director of Nursing (DON) was asked, Should your staff follow and implement a fall Care Plan? She stated, Yes. She was asked, How are you supervising the implementation of Care Plans? She stated, We have Stand-up Meetings in the morning, and we address the issue. At one point, (Staff) was doing Care Plans and she puts the information in, or if there is an I and A (Incident and Accident) with interventions, she puts them in the computer, on paper, and on the Closet Care Plans. We make rounds too. She was asked, Should staff follow physician's orders [REDACTED]. h. On 8/21/2020 at 12:07 p.m., the Minimum Data Set (MDS) Coordinator was asked, Should (Resident #1) have slides on? She stated, No. He should have skid proof socks and good fitting shoes on. She was asked, Should he have had a fall mat? She stated, Yes. She was asked, Should he be supervised while outside? She stated, Yes. 2. Resident #2 had [DIAGNOSES REDACTED]. The Annual MDS with ARD of 6/15/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; required limited one-person assistance with bed mobility; and transfer; and had one fall without injury since admission or prior assessment. a. A facility Incident and Accident Report dated 5/21/2020 at 2:30 a.m. documented, .Called to Unit by CNA (Certified Nursing Assistant) for resident in hallway floor. CNA states resident lost balance. Denies injury to head. Skin tear to R (right) elbow . Additional comments . Resident to wear non-skid socks when not wearing shoes . b. A facility Incident and Accident Report dated 7/19/2020 at 10:45 p.m. documented, .Resident noted on floor beside bed. States he was just laying down. Denies pain or injury. Assisted up and back to bed . Additional comments . Assisted resident back to bed, Resident known to sit or lay in floor by choice . Neuro (Neurological) checks in case of fall . Measures to prevent further falls . Res (Resident) known to lay or sit in floor purposefully . Resident is Care Planned to purposefully lay / sit in floor . c. A facility Incident and Accident Report dated 7/30/2020 at 2:24 a.m. documented, .Notified of resident in floor, R (right) elbow skin tear. R (right) knee skin abrasion. 1st (First) aid given without issues. Resident slid from bed to floor . Additional comments . Referral for follow-up visit with Tele-Health Unit Behavioral Health . Decrease [MEDICATION NAME] Sprinkle to 500 mg (milligrams) (at) 0800 (8:00 a.m.) and 250 mg (at) 1700 (5:00 p.m.) . d. A facility Incident and Accident Report dated 7/31/2020 at 7:40 a.m. documented, .Called to res (resident's) room. Resident found in floor beside bed. Blankets under feet. Denies any pain. 4 cm (centimeter) (by) 1.5 cm skin tear to outer L (left) forearm . Measures to prevent further falls . Labs (laboratory tests) ordered, follow-up with Tele-Health Unit Behavioral . e. The Care Plan with a revised date of 7/31/2020 documented, .Problem . Resident was on floor with blankets noted off bed and under resident's feet . Goal . Resident's skin tear to left forearm will heal without complications. Any fall or injury will be noted and addressed with goal of prevention of another fall or injury . Approach . Bed alarm to bed. Ensure functioning properly . Approach . Obtain labs (laboratory tests) UA (Urinalysis), CMP (Complete Metabolic Panel), [MEDICAL CONDITION] Panel, PSA (Prostate-Specific [MEDICATION NAME] Test) . Approach . Staff to ensure non-skid socks are on feet . (Chartable take in POC (Plan of Care)) . Approach . Treat skin tear to left forearm as ordered per MD (Medical Doctor) . f. The physician's orders [REDACTED]. Bed Alarm . Check Proper Placement Q (every) Shift . g. The Medication Administration Record [REDACTED]. Check Proper Placement Q Shift . Task Completed on 8/20/2020 Day Shift by (Name) RN (Registered Nurse) . Evening shift by (Name) RN . Night Shift by (Name) RN . Task Completed on 8/21/2020 Day Shift by (Name) RN . h. On 8/20/2020 at 2:42 p.m., Resident #2 was lying in bed. The resident had orange non-skid socks on. The call light was on the floor behind the head of the bed. There was no floor mat or bed alarm in place. (The Surveyor took a photograph of the call light and the bedside at this time.) i. On 8/21/2020 at 10:01 a.m., Resident #2 was lying in bed with head covered by a comforter and with feet uncovered. The resident had orange non-skid socks on. The call light was within reach. No bed alarm was in place. (The Surveyor took a photograph at this time.)</p>		

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

TITLE

(X6) DATE

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.