STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425314	A. BUILDING _____ B. WING _____	**03/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN OAKS REHABILITATION AND HEALTHCARE CENTER	**109 BENTZ ROAD PIEDMONT, SC 29673**

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 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined the facility failed to provide supervision to prevent falls, failed to investigate the root cause of fall, and failed to review care plan interventions and develop new care plan interventions for falls for one (Resident #11) of three sampled residents reviewed for falls. This resulted in Resident #11 sustaining a [MEDICAL CONDITION] that required surgical intervention. The findings included: Resident #11 had [DIAGNOSES REDACTED]. The resident #11 care plan documented on 01/31/2019 that a bed alarm was placed and on 03/13/2019 the resident was to have visual checks every 30-minute for two weeks. There was no further clinical documentation that the 30-minute checks were to be continued after the initial two week period. The facility's fall risk evaluation dated 03/14/2019, documented a fall risk score of 14. The evaluation form stated any score above a 10 represented a high fall risk. The fall evaluation documented the required interventions to include: alternate bed placement, assist with transfers/mobility as needed, encourage alternate periods of activity with periods of rest, observe for fatigue, encourage to participate in activities of Resident's choice, place call light within reach, encourage Resident to ask for assistance with transfers, provide Resident with an assistive device for ambulation and transfers as appropriate, and provide Resident with a clutter free environment with unobstructed pathways. An incident report dated, 05/22/2019 at 5:59 AM, documented the resident was found sitting on the floor with her/his back against the wheelchair (wc). No injuries were noted and as a result of the fall, the intervention put in place was to have Physical Therapy check the wheelchair seat. There was no documentation the facility had investigated the fall to determine the root cause of the fall. No additional care plan interventions to prevent future falls were initiated. An incident report, dated 06/26/2019 at 7:25 AM, documented the resident was found on the floor, on her/his left side in front of the wc. The resident exhibited pain when her/his left hip was palpated. X-rays were ordered. No results of the X-rays were available for review during the survey. S/he did not require a transfer to the hospital. The resident's care plan documented the wc cushion was replaced. There was no documentation the facility had investigated the fall to determine the root cause of the fall. No additional care plan interventions to prevent future falls were initiated. An incident report, dated 07/11/2019 at 6:30 AM, documented the resident was observed on the floor on her/his right side. No injuries were noted. The incident report also documented the resident consistently slumped and slid down the wc seat. There was no documentation the fall was investigated to determine the root cause of the fall. There was no documentation of new care plan interventions to prevent future falls having been initiated. The resident's annual Minimum Data Set (MDS) assessment, dated 09/06/2019, documented the resident was moderately impaired in cognition. S/he required extensive assistance for activities of daily living (ADLs). An incident report dated 09/06/2019 at 5:45 AM, documented the resident was found on the floor in the dayroom in front of her/his wc. S/he was on her/his right side. S/he was assisted back to the wc and was observed to have an abrasion and discoloration to the back of her head. The report documented no additional injuries were noted. A nurse's note dated 09/06/2019 at 9:18 AM, documented the restorative aide was assisting the resident to the main dining room when s/he noticed the resident's right foot was rotated inward and the resident was unable to lift her/his leg. S/he was assisted to bed and evaluated for pain. A clinical record documented on 09/06/19, the physician was notified and x-rays were ordered. The results were positive for right intertrochanteric fracture ([MEDICAL CONDITION]). The resident was transferred to a local hospital for higher care. S/he had surgery and returned to the facility. The resident's care plan documented a new intervention was put in place after the resident's fall, on 09/06/2019. The new intervention was to offer the Resident the option to sleep in instead of an early wake up. On 03/25/2020 at 4:00 PM, Certified Nurse Aide (CNA) #1 was asked what time s/he had got Resident #11 out of bed the morning of 09/06/2019. S/he stated s/he always got the resident up at 5:00 AM. S/he was asked if the resident wished to get up that early. The CNA stated s/he had been told the family wanted the resident to get up early. S/he was asked if the resident would fall asleep in her/his wc. The CNA responded All the time. S/he then added she had told the nurses that the resident was getting up too early, but they told her/him the family had requested the early wake up. The CNA stated the resident was always falling asleep and sliding out of the wc. The CNA was asked if the resident was on frequent visualization checks. S/he stated s/he was never told to do that. On 03/26/2020 at 10:00 AM, Licensed Practical Nurse (LPN) #1 was interviewed. S/he stated the resident fell out of the chair often. S/he stated they frequently had to pull her/his up and prevent falling out of the wc. S/he stated the pommel cushion didn't help and thought it made sliding out of the chair worse. S/he was asked if the resident was on frequent visual checks. S/he stated s/he didn't think so and that the resident wandered around the facility in her wc. The LPN was asked if the resident had any other interventions in place to prevent falls from the wc. S/he stated s/he didn't think so. On 03/25/2020 at 2:00 PM, the Corporate Vice President of Clinical Services was interviewed. S/he was asked for documentation proving the falls had been investigated to determine the root cause of the falls. S/he stated there was no documentation. S/he was asked if the resident was on a get up list from the night shift. S/he stated s/he didn't know. S/he was asked if additional interventions had been initiated. S/he stated there was no documentation of any. S/he added that no one who was directly involved with the fall remained employed at the facility. S/he stated s/he assumed Resident #11 was on the night shift get up list.

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.