STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015128	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, MOULTON	300 HOSPITAL STREET MOULTON, AL 35650

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 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the call light was always in reach of Resident Identifier (RI) #10. During the tracking of RI #10 on 7/30/2014, two observations were made of the call light out of reach of RI #10, which prevented the resident from using the call light to call for assistance. This affected 1 of thirteen sampled residents. Findings include: The facility's policy and procedure for Call Lights, provided from the facility's Procedures Manual, defined the . Objective: A call light alerts the staff to respond to a patient's request for help . One of the procedures included: . 8. Be sure the call light is always within easy reach of the resident. RI #10 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. RI #10's medications included Laxis 80 milligrams times one every day for [MEDICAL CONDITION]. Review of RI #10's 4/16/2014 Annual Minimum Data Set (MDS) assessment indicated the resident's cognition was intact, scoring a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS). The MDS also revealed RI #10 required extensive assistance with two person physical assist for toileting. The resident was also indicated with impairment on one side in the upper extremity and impairment on both sides of the lower extremity. RI #10's MDS revealed the resident was always incontinent of both bowel and bladder. Review of RI #10's care plans revealed a problem of the resident being at risk for falls related to weakness, balance problems . use of diuretic . incontinence. An approach included . Call light in reach and answered timely . On 7/30/2014 at 11:20 AM, an observation was made of RI #10 sitting in her wheelchair on the right side mid way down the bed. The call light was observed attached to the bed sheet at the head of the bed on the right side, behind the resident. On 7/30/2014 at 12:25 PM, the call light was observed wrapped around the left backside of the wheelchair arm rest, on the resident's right side and out of reach for the resident. RI #10 was asked if the call light could be reached. The resident held up the right arm and the hand was observed to be contracted. The resident was asked if the call light could be reached with the left hand. The resident brought the left hand and arm around the front side of the torso. The resident could not reach the call light with the right hand. On 7/31/2014 at 11:05 AM, RI #10 was asked if staff kept the call light where it could be reached. The resident replied sometimes they do and sometimes they do not. RI #10 was asked by the call light being out of reach, did that keep the resident from calling for assistance when there was a need to toilet. The resident said they would holler and the staff would come in and asked what was needed. RI #10 said the staff would be told the call light was needed. This deficient practice was written as a result of the investigation of complaint #AL 574.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency was written as a result of complaint #AL 530. Based on interviews and record reviews, the facility failed to ensure EI (Employee Identifier) #3, an LPN (Licensed Practical Nurse), EI #4, a CNA (Certified Nursing Assistant), EI #5, a CNA, and EI #6, a CNA, safely transported RI (Resident Identifier) #1, a dependent, confused, non-ambulatory resident, in a manner to prevent a fall with injuries. On [DATE] at 8:12 PM, a fire was discovered in the shower room next to RI #1's room. EI #6 transported the resident away from the fire without incident. After the fire department gave clearance, residents were transported back to their rooms. RI #1 was placed on a backboard, used by facility staff to perform CPR (Cardio Pulmonary Resuscitation). RI #1 was not secured to the backboard. Upon entering the resident's room, EI #s 3, 4, 5, and 6 held the backboard suspended approximately two and one half feet above the floor for approximately five to ten minutes, while EI #12, another CNA, made RI # 1's bed. RI #1 fell facedown off the suspended board onto the floor, hitting their head on a dresser/night stand. As a result of the fall, the resident was rendered unconscious and sustained two hematomas to the head. RI #1 was transported to a local emergency roiagnom on [DATE] and treated for [REDACTED]. According to the staff who transferred the resident, EI #s 3, 4, 5, and 6, they used the backboard to transfer RI #1 even though they had no prior training on using this device to transport residents. This affected RI #1, one of two residents transported by a backboard on [DATE]. This deficient practice posed an immediate threat to the health and safety of residents, as it is likely to cause serious harm, injury, impairment, or death. On [DATE] at 7:32 PM, the Administrator, DON (Director of Nursing), Senior Vice President, and two Regional Nurses were made aware that the surveyors identified an Immediate Jeopardy level J at F 323. The Immediate Jeopardy began on [DATE] and was relieved on [DATE] at 9:30 PM, when it was verified the facility implemented immediate corrective actions to remove the immediacy. The scope and severity of F 323 was lowered to a D level to allow the facility time to monitor and if necessary, revise their corrective actions to achieve substantial compliance with F 323. Findings include: On [DATE] at 3:52 PM, the Alabama Department of Public Health, Division of Health Care Facilities received a complaint alleging RI #1 had been dropped by facility staff while being transported on an unsecured backboard causing injury to the resident. A review of facility's undated policy titled, TRANSFER, ONE MAN CRADLE DROP CARRY FOR USE IN EMERGENCY AND DISASTER SITUATIONS, revealed the following: PURPOSE: Designated partner will use a one person cradle drop carry in emergency situation only. OBJECTIVE: Rapid evacuation of non-ambulatory patients using available partners. PROCEDURE: 1. Position blanket on floor so there is plenty of room above patient's head. 2. Remove legs from bed. 3. Hold patient at shoulder. 4. Get to your knees. 5. Slide patient from bed. 6. Wrap blanket around patient if overactive. 7. Two assistants maybe required on carpet. CRADLE DROP: * Grip under shoulders and hips. Put blanket on floor. * Slide to edge of bed. * On one knee or both knees slide patient down your chest. * Pull him out headfirst on blanket. NHC South Central Region Procedures Manual RI #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS (Minimum Data Set) dated [DATE], revealed RI #1 identified as cognitively impaired for daily decision making as evidenced by inability of the resident to complete a Brief Memory Assessment. RI #1 was identified as having short and long term memory impairment and was as totally dependent on staff for all activities of daily living, including transfers. RI #1 did not ambulate. A review of the care plan dated [DATE] revealed RI #1 was . at risk for falls related to weakness, decreased physical functioning, history of falls, incontinence, cognitive impairment and use of psychotropic medications and diuretics.Approaches Extensive-dependent assistance with transfers and mobility. A review of the EMS (Emergency Medical Service) report dated [DATE] revealed RI #1 was identified as a Fall Victim. EMS staff were present with RI #1 at 9:11 PM. The Chief Complaint: POSS (Possible) HEAD INJURY UNSP (Unspecified), Primary Symptom: Change in Responsiveness, Location: Head, Primary Impression: 959.90- Traumatic Injury, Secondary Impression: 959.90- Traumatic Injury Mechanisms: Blunt; Injury: Yes;. Cause: Falls . Narrative EMS ON SCENE . EMS WERE CALLED TO A ROOM WHERE . PATIENT HAD BEEN DROPPED FROM APPROXIMATELY 3 FEET TO THE FLOOR LANDING HEAD FIRST ON THE FLOOR POSITIVE LOSS OF CONSCIOUSNESS . A review of the facility's investigation regarding RI #1 revealed, .Date of fall: [DATE] Time of fall: 9:30 PM FALLS TEAM MEETING NOTES Summary of meeting: Systemic or operational conditions that may contribute to falls? Any patterns or trends to the patient's falls? Pt (Patient) was being transferred by staff to bed via backboard after hall was evacuated. Pt

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.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) became agitated and combative + (and) rolled off backboard to the floor. She landed on her abdomen, side and head. Had hematoma + (and) bruise noted to the forehead. Conclusion: MD (Medical Doctor) + (and) family notified. Pt sent for evaluation and treatment related to unresponsiveness with stable vital signs and hematoma to head. Results: No abuse or neglect suspected. This section was signed by EI #15 an LPN (Licensed Practical Nurse) A review of the FSI- FALL SCENE INVESTIGATION REPORT, page 1 of 3, revealed, Patient Name: (RI #1's name) Date of Fall: [DATE] Time of Fall: 9:30 PM Staff/Witness present at/or finding patient after fall: (EI #3's name) Draw a picture of area and position in which patient was found. The drawing indicated a six-sided backboard with a narrow opening at the head (wide end) and a narrow opening at the foot (narrow end) of the backboard. EI #3 (LPN) was positioned at the head of the backboard, EI #6 (CNA) was located on the left side at the foot of the backboard, EI #5 (CNA) was located at the direct end (foot) of the backboard, and EI #4 (CNA) was located on the right side at the foot of the backboard. Three arrows were drawn indicating the resident rolled off towards the right side of the backboard. Fall Summary Fall to floor (witnessed) (box checked) What was resident doing during or just prior to fall? Transfer assisted by staff (box checked) Fall location Patients room (box checked).Describe patient's mental status prior to fall: Awake with confusion. ROOT CAUSE OF THIS FALL Review of contributing factors: Mood or mental status (checked) What appears to be the initial root cause(s) of the fall? Resident's restlessness and sudden movement on transfer backboard Describe initial interventions to prevent future falls: If using a transfer backboard, use one with straps NURSE COMPLETING FORM: (EI #3's name) Date and Time: [DATE] 12:30 Included in the investigation were the following handwritten statements: EI #6's (CNA) statement, dated [DATE], revealed RI #1 was placed on a carrying board. The resident began to panic as staff members were carrying the resident to the bed. The staff paused in the resident's room while they waited for RI #1's bed to be made. RI #1 panicked because the resident was frightened about the fire earlier and for being carried. RI #1 began to struggle to get free and then rolled to the resident's right and rolled off the carrying board. RI #1's head was struck on the night stand. EI #6 indicated he did not see any straps securing RI #1 to the backboard. EI #4's (CNA) statement, dated [DATE], revealed she assisted EI #s 3, 5, and 6 to return RI #1 to the resident's room on a backboard. After entering the resident's room, staff had to wait for the bed to be made. EI #4 indicated the resident fell to the right off the backboard and onto the floor. EI #5's (CNA)undated statement, indicated four (EI #s 3, 4, and 6) people were holding the board as they were waiting for RI #1's bed to be made. RI #1 became agitated and was trying to roll. The resident rolled off toward the dresser and hit their head. A review of RI #1's the local hospital history and physical dated [DATE] revealed, RI #1 presented to the emergency department CHIEF COMPLAINT: Fall, Closed head trauma. The resident presented with a complaint of fall and injury. The report indicated, There was a fire at the nursing home and the patient was moved due to her room being next door to where the fire started. The patient was being put back in (RI #1's) room and (RI #1) was dropped off the backboard, face first, and (RI #1) was noted to have a hematoma on (RI #1's) forehead, skin tear to the left hand. The patient admitted to the hospital for observation due to closed head trauma. An interview was conducted with a member of the fire department on [DATE] at 3:56 PM. The fireman stated he was across the hall from RI #1's room at the time of the fall and responded to a thud and screams. The fireman stepped into the resident's room and saw RI #1 on the floor. On [DATE] at 4:39 PM an interview was conducted with the Paramedic who was onsite and responded to RI #1's fall. The Paramedic observed RI #1 dazed, with a hematoma on the head and semi-responsive. Staff reported to the Paramedic that the backboard tilted and RI #1 fell face first on the floor. During a subsequent interview on [DATE] at 7:37 AM the Paramedic stated he was informed by staff that RI #1 was unconscious for 2 to 3 minutes following the fall. An interview was conducted with EI #4 on [DATE] at 5:26 PM. EI #4 (CNA) assisted with returning RI #1 to the room using a backboard. EI #4 did not know where the backboard came from and stated she had never seen it before. EI #4 recalled waiting in the room with the other staff members (EI #3, 5, and 6) for RI #1's bed to be made ready and stated, .the next thing I know she tilted and flipped over. When asked what was in place to keep RI #1 from falling, EI #4 responded, Nothing. When the surveyor inquired what training had EI #4 received regarding use of the backboard, EI #4 reported none and that was the first time EI #4 had ever used a backboard. An interview was conducted on [DATE] at 7:37 AM with EI #5 (CNA), who assisted with RI #1's transfer using the backboard. EI #5 stated she had never seen the backboard before. EI #5 explained that while waiting for RI #1's mattress to be put on the bed, .the resident was wiggling and kind of fighting us, before we knew it she was in the floor. When asked what was in place to keep RI #1 from falling, EI #5 replied, I don't remember anything. EI #5 reported she had no training on use of the backboard until after the incident. When asked if the backboard was a safe choice for transporting RI #1 back to her room, EI #5 responded that initially it was thought to be. However, EI #5 indicated that was no longer her opinion. When EI #5 was asked why the backboard would not be considered the safe choice for transporting RI #1, EI #5 answered, Because (RI #1) got hurt and it could have been prevented. On [DATE] at 8:17 AM, a telephone interview was conducted with EI #6, CNA who participated in transporting RI #1 back to the room using the backboard. When asked where the board came from, EI #6 reported, I have no idea, I had never seen that board before. EI #6 recalled that the staff members were walking in the room and the bed was not ready. The person on the side of the board moved it. (RI #1) was panicky and rolled. EI #6 reported receiving no training on use of the backboard prior to [DATE]. EI #6 further explained staff figured with 4 people it would be safe, but it was a poor choice because RI #1 was panicking and could fall. On [DATE] at 12:57 PM, an interview was conducted with EI #12, the CNA who prepared RI #1's bed at the time of the fall. EI #12 reported that before RI #1 could be put in the bed, she had to put the air mattress back in place and make up the bed. EI #12 estimated this task took no more than 5 to 10 minutes. On [DATE] at 1:20 PM, an interview was conducted with EI #3 (the LPN in charge nurse on the date of the incident). EI #3 reported assisting with transporting RI #1 back to the room on a yellow strapless backboard. When asked why, EI #3 responded, That was all we had. EI #3 did not know who made the decision to transport RI #1 using the backboard. When EI #3 was asked who was in charge at the time of the code for EI #3's area, EI #3 answered, Me. EI #3 did not know where the backboard came from or had ever seen the backboard before. EI #3 recalled the events of the incident as follows, .We are holding (RI #1), a CNA is fixing the bed, . we were waiting, standing at attention, everybody still. EI #3 further explained he thought RI #1 became confused and restless. EI #3 described how the resident was suspended two and half feet off the floor. When asked what was in place to keep the resident from falling off the side, EI #3 responded, Nothing really. EI #3 admitted RI #1 had a history of [REDACTED]. EI #3 was asked if the backboard was a safe choice for transporting the resident back to the room EI #3 answered, No Ma'am. When asked why, EI #3 answered, The straps are needed. EI #3 denied having received any training regarding the use of the backboard. In a subsequent interview on [DATE] at 10:02 AM, , EI #3 was asked how long had RI #1 had been unconscious after the fall. EI #3 estimated RI #1 had been unconscious for about a minute. On [DATE] at 10:23 AM, the surveyor requested the policy for the backboard. EI #2, the DON (Director of Nursing), reported, We don't have a policy on the backboard. The board is what we use for CPR. An interview was conducted with EI #11, an RN (Registered Nurse), on [DATE] at 2:28 PM. EI #11 reported if the resident can't get up, staff were trained to cradle scoop. When asked what would have been the safest mode per policy to transfer RI #1 back to the room, EI #11 answered, The scoop slide with sheet. An interview was conducted with EI #9, RN, on [DATE] at 1:34 PM. EI #9 reported seeing the backboard after the fall in RI #1's room. EI #9 reported that EI #7, a CNA, had suggested the backboard be used for another resident and had retrieved it from downstairs in Central Supply. EI #9 indicated she had not received any training regarding the backboard. EI #9 was asked if the backboard was a safe choice for transporting the resident back to the room. EI #9 responded, I don't think so, we could have just put (RI #1) in the room by ourselves. EI #9 did not know why RI #1 was transported on the backboard, and stated, It wasn't called for. An interview was conducted on [DATE] at 2:15 PM with EI #10, LPN. EI #10 reported being across the hall, hearing a commotion, then stepping into RI #1's room. When asked what was observed, EI #10 said RI #1 was in the floor and EI #3, LPN, was assessing the resident. EI #10 went in to help and observed RI #1 unconscious with a knot forming on the forehead. EI #10 reported observing RI #1 unconscious for one and one-half minutes before leaving the resident's room. EI #10 did not recall receiving any training on use of a backboard. EI #10 reported she thought the chair to be a safer choice for transporting RI #1. An interview was conducted with EI #2, DON on [DATE] at 3:49 PM. EI #2 reported that according to the investigation, RI #1 was transported back to the room using the backboard, but did not know why. EI #2 stated that at times, RI #1 did have restlessness and combative behaviors. EI #2 did not know who made the decision to place RI #1 on the backboard. EI #2 was asked what precautions were taken to keep the resident safe while being transported back to the room. EI #2 responded, There was adequate staff assisting with the transfer. There was no rush. I actually saw them transporting (RI #1) down the hall and never once thought that it was an unsafe action. When asked what did the facility policy say regarding transferring the resident during an emergency, EI #2 answered, If we can't use wheelchair, we use the slide. EI #2 was asked if transferring the residents on backboards without securing them, was a safe use of equipment and EI #2 answered, No. EI #2 reported staff had not received training regarding using backboards prior to [DATE]. EI #2 was asked if

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) a resident should be suspended on a backboard, unsecured. EI #2 responded, I feel like if the persons felt like they were in control, it should be safe. When asked why wasn't a board with straps used for RI #1 on [DATE], EI #2 answered, I don't know. EI #2 reported there was no policy in place regarding backboards. An interview was conducted with EI #1, the Administrator on [DATE] at 4:58 PM. EI #1 reported that RI #1 was transported back to the room utilizing a backboard. When asked what precautions should have been taken, EI #1 answered, Straps could have been a precautionary. EI #1 reported that transferring residents on backboards without using straps was not considered to be safe use of equipment. EI #1 stated staff had not received training regarding the use of backboards prior to [DATE]. EI #1 was asked if a resident should be suspended on a backboard, unstrapped. EI #1 answered, Probably not. EI #1 confirmed that the facility did not have a policy in place regarding the backboards and stated the policy regarding transferring RI #1 back to the room was not followed. EI #1 reported the staff members were trained on safe modes of transport during an emergency situation, but none of the methods included a backboard. During a subsequent interview with EI #1 on [DATE] at 6:04 PM, EI #1 stated prior to the incident, staff should have secured RI #1 to the backboard to prevent the resident from falling. EI #1 stated there had not been about monitoring or follow-up after the incident. ********** Allegation of Compliance (AOC) F323 On [DATE] at 9:01 PM, the facility provided the surveyors with an acceptable AOC, which documented: F323 Incidents/Accidents 1. Corrected Actions Accomplished For the Patient Found To Have Been Affected By The Allegedly Deficient Practice -On [DATE] transfer backboard was removed from use in the center -Patient #4181 care plan was updated to remove emergency use of transfer board 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken -Overseen by (name of Regional Nurse) and completed on [DATE] a review of all patient care plans to ensure back board was not listed as a transfer device and appropriate transfer devices were care planned -(Name of Regional Nurse) in-serviced the DON and ADON on the centers non-use of transfer backboards and the requirement to receive training prior to the use of any new transfer devices on [DATE] 3. The Measures We Have Put In Place And Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. -Overseen by (name of Regional Nurse) in-service training was conducted with the nursing staff on [DATE] of the center's policies related to back boards for transfers. Specific training was given regarding the requirement to receive training prior to use of any new transfer devices. -Overseen by (name of Regional Nurse), any partners that are on leave or otherwise unavailable will be in-serviced prior to their next shift worked. -(Name of Regional Nurse) will in-service Administrator and DON regarding the centers policy of the non-use of transfer back boards and the requirement that all partners must receive training prior to use of any new transfer devices completed on [DATE] 4. The Corrective Actions Will Be Monitored To Ensure The Practice Will Not Recur. -Beginning the week of [DATE] an interview QA (Quality Assurance) will be conducted by the ADON assessing partner knowledge regarding use of new transfer equipment and devices used to transfer patients. 3 nursing partners will be questioned each week times 4 weeks ensuring understanding of receiving training prior to using any new transfer devices and the center's policies related to the non-use of back boards for transfers. -All Quality Assurance studies and monitors will be reported to the center's Quality Assurance Committee which consists of Administrator, DON, Medical Director, Registered Dietician, Social Worker, and Health Information Manager. Each study and monitor will continue as directed by the Quality Assurance Committee. ********** After reviewing and verifying the implementation of the facility's acceptable Allegation Of Credible Compliance, the immediate jeopardy was relieved on [DATE] at 9:30 PM. The scope and severity was lowered to D level to allow the facility time to monitor/revise their corrective actions.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency was written as a result of complaint #AL 530. Based on interviews and record reviews, the facility administration failed to develop and implement a policy and/or procedure for the use of a backboard. On [DATE], staff placed RI #1 on a backboard for transport to the resident's room. According to facility staff, the backboard was used to perform CPR, (Cardio [MEDICAL CONDITION] Resuscitation). RI #1 was not secured to the backboard and fell facedown onto the floor, hitting their head on a dresser/night stand. As a result of the fall, the resident was rendered unconscious and sustained two hematomas to the head and a skin tear. RI #1 was transferred to a local emergency room and treated for [REDACTED]. This affected RI #1, one of two residents transported by a backboard on [DATE]. This deficient practice posed an immediate threat to the health and safety of residents, as it is likely to cause serious harm, injury, impairment, or death. On [DATE] at 7:32 PM, the Administrator, DON (Director of Nursing), Senior Vice President, and two Regional Nurses were made aware that the surveyors identified an Immediate Jeopardy level J at F 490. The Immediate Jeopardy began on [DATE] and was relieved on [DATE] at 9:30 PM, when it was verified the facility implemented immediate corrective actions to remove the immediacy. The scope and severity level of F 490 was lowered to a D level to allow the facility time to monitor and if necessary, revise their corrective actions to achieve substantial compliance with F 490. Findings include: Refer to F323. On [DATE] at 3:52 PM, the Alabama Department of Public Health, Division of Health Care Facilities received a complaint alleging RI #1 had been dropped by facility staff while being transported on an unsecured backboard causing injury to the resident. A review of the Administrator's job description, dated [DATE] revealed: The Administrator has complete administrative and managerial responsibilities within the health care center, ., coordinator, and support person for Department Directors, other partners, .DUTIES AND RESPONSIBILITIES: .9. Ability to interpret and implement regulations (state and federal). 10. Ability to organize and implement systems. 16. Promote safety awareness through center activities, safety committee and incentive programs . A review of the Director of Nursing's job description, dated [DATE], revealed: The DON has administrative and managerial authority, responsibility, and accountability for the function, activities, and training of the Nursing Services' Staff. The DON is under the direction of the Administrator. PERFORMANCE REQUIREMENTS: Special Demands: .5. Ability to interpret and implement regulations (state and federal). 6. Ability to organize and implement systems. 10. Working knowledge of center's fire, safety, and disaster procedures. DUTIES AND RESPONSIBILITIES: I. PATIENT CARE MANAGEMENT A. GENERAL DESCRIPTION: .2. Implements federal, state, and local regulations pertaining to nursing services. 3. Assesses the implementation of effective strategies and methods of delivery of nursing services. II. OPERATIONAL MANAGEMENT A. GENERAL DESCRIPTION: .2. Participates in development of institutional policies. 5. Administers policies and formulates procedures for the nursing department. 9. Manages .training, . of all nursing staff. B. SPECIFIC ITEMS: 1. Participates in development and maintenance of nursing services' philosophy and objectives, standards of practice, policy and procedure. A review of the EMS (Emergency Medical Service) report dated [DATE] identified RI #1 as a Fall Victim. EMS staff were present with RI #1 at 9:11 PM. The report documented RI #1's chief complaint as a possible head injury. The report further documented RI #1 had been dropped approximately 3 feet from a back board landing head first on the floor and losing consciousness. A review of the facility's investigation regarding RI #1 revealed, .Date of fall: [DATE] Time of fall: 9:30 PM, . ROOT CAUSE OF THIS FALL . Resident's restlessness and sudden movement on transfer backboard Describe initial interventions to prevent future falls: If using a transfer backboard, use one with straps NURSE COMPLETING FORM: (EI #3's name) Date and Time: [DATE] 12:30 RI #1's hospital history and physical dated [DATE] revealed, RI #1 presented to the emergency department CHIEF COMPLAINT: Fall, Closed head trauma. On [DATE] at 10:23 AM, the surveyor requested the policy for the backboard. EI #2, the DON (Director of Nursing), reported, We don't have a policy on the backboard. The board is what we use for CPR. An interview was conducted with EI #2, DON, on [DATE] at 3:49 PM. EI #2 reported that according to the investigation, RI #1 was transported back to the room via backboard, but did not know why. EI #2 reported that at times, RI #1 did have restlessness and combative behaviors. EI #2 was asked what precautions were taken to keep the resident safe while being transported back to the room. EI #2 responded, There was adequate staff assisting with the transfer. There was no rush. I actually saw them transporting (RI #1) down the hall and never once thought that it was an unsafe action. When asked what did the facility policy say regarding transferring the resident during an emergency, EI #2 answered, If we can't use wheelchair, we use the slide. EI #2 was asked if transferring the residents on backboards without securing them, was a safe use of equipment and EI #2 answered, No. EI #2 reported staff had not received training regarding using backboards prior to [DATE]. EI #2 was asked what could be the potential negative outcome if a resident was transported on a backboard without being secured to the board. EI #2 responded, It depends on the resident and their status, it could be anything from skin tear, to fracture, to no injury. EI #2 reported there was no facility policy in place regarding backboards. EI #2 further added that the purpose of implementing policies was to keep residents safe. An interview was conducted with EI #1, the Administrator on [DATE] at 4:58 PM. EI #1 reported that RI #1 was transported back to the room utilizing a backboard. When asked what precautions should have been taken, EI #1 answered, Straps could have been a precautionary. EI #1 reported that transferring residents on backboards without using straps was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015128	A. BUILDING _____ B. WING _____	**08/01/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, MOULTON	**300 HOSPITAL STREET MOULTON, AL 35650**

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) not considered to be safe use of equipment. EI #1 stated staff had not received training regarding the use of backboards prior to [DATE]. EI #1 was asked if a resident should be suspended on a backboard, unstrapped. EI #1 answered, Probably not. EI #1 confirmed that the facility did not have a policy in place regarding the backboards and stated the policy regarding transferring RI #1 back to the room was not followed. EI #1 reported the staff members were trained on safe modes of transport during an emergency situation, but none of the methods included a backboard. ********** Allegation of Compliance (AOC) F490 On [DATE] at 9:01 PM, the facility provided the surveyors with an acceptable AOC, which documented: F490 Administration 1. Corrected Actions Accomplished For The Patient Found To Have Been Affected By The Allegedly Deficient Practice -On [DATE] transfer backboard was removed from use in the center -Patient # 4181 care plan was updated to remove emergency use of transfer board 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken -Overseen by (name of Regional Nurse) and completed on [DATE] a review of all patient care plans to ensure back board was not listed as a transfer device and appropriate transfer devices were care planned (Name of Regional Nurse) in-serviced the DON and ADON on the centers non-use of transfer backboards and the requirement to receive training prior to the use of any new transfer devices on [DATE] 3. The Measures We Have Put In Place And Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. -Overseen by (name of Regional Nurse), in-service training was conducted with the nursing staff on [DATE] of the center's policies related to back boards for transfers. Specific training was given regarding the requirement to receive training prior to use of any new transfer devices. -Overseen by (name of Regional Nurse), any partners that are on leave or otherwise unavailable will be in-serviced prior to their next shift worked. -(Name of Regional Nurse) will in-service Administrator and DON regarding the centers policy of the non-use of transfer back boards and the requirement that all partners must receive training prior to use of any new transfer devices completed on [DATE] 4. The Corrective Actions Will Be Monitored To Ensure The Practice Will Not Recur -Beginning the week of [DATE] an interview QA (Quality Assurance) will be conducted by the ADON assessing partner knowledge regarding use of new transfer equipment and devices used to transfer patients. 3 nursing partners will be questioned each week times 4 weeks ensuring understanding of receiving training prior to using any new transfer devices and the center's policies related to the non-use of back boards for transfers. -All Quality Assurance studies and monitors will be reported to the center's Quality Assurance Committee which consists of Administrator, DON, Medical Director, Registered Dietician, Social Worker, and Health Information Manager. Each study and monitor will continue as directed by the Quality Assurance Committee. ********** After reviewing and verifying the implementation of the facility's acceptable Allegation Of Credible Compliance, the immediate jeopardy was relieved on [DATE] at 9:30 PM. The scope and severity was lowered to D level to allow the facility time to monitor/revise their corrective actions.