DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Received 8/8/11

PRINTED: 07/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with staff, the resident and family members; the facility failed to reassess and implement interventions to address the positioning needs of a resident (Resident #135) that had left sided weakness to prevent further falls from the wheelchair and provide proper positioning in the wheelchair after 2 falls. This was evident in 1 of 3 residents at risk for falls. Findings include: Resident # 135 was admitted to the facility on 5/2/11 with a cumulative diagnosis of CVA (cerebral vascular accident) with left sided weakness. According to the 5/23/11 initial MDS (Minimum Data Set) Resident #135 was alert and oriented and able to make his needs known. The resident required extensive assistance with all activities of daily living due to his left sided weakness. This included transfer, activities of daily living and bed mobility. The MDS documented under Physical Performance Limitations: gait, balance, strength and muscle endurance, the resident had impaired balance	F 323	F323 Free of Accident Hazards/ Supervision/ Devices The facility will reassess and implement interventions to address the positioning needs of a resident to prevent further falls and provide proper positioning in a wheelchair. * Corrective action has been accomplished for the resident found to have been effected by the deficient practice by providing the resident with a wedge cushion and adjusted the L arm support tray 5/27/11. * Corrective action has been accomplished for those residents' having potential to be effected by the deficient practice by the Quality Assurance Nurse and therapy department conducting inservices with the nursing staff from 6/10/11 to 6/16/11 regarding positioning	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Douglas P. Russell
TITLE: NHA
(X6) DATE: 6/21/11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 during transitions, but did not indicate difficulty maintaining sitting balance. Under the analysis of findings it indicated he had a CVA with left sided weakness and referred to PT (physical therapy) and OT (occupational therapy). The MDS indicated the resident needed 1 to 2 person assistance with activities of daily living (ADLs). Review of the falls assessment dated 5/2/11 revealed the resident was a falls risk due to his diagnosis of left sided weakness. Review of the PT initial evaluation dated 5/3/11 documented the goal to increase sitting and standing balance to decrease falls risk. Resident # 135 had decreased balance while sitting. Review of the OT initial evaluation dated 5/4/11 documented the goals to demonstrate fair sitting balance to increase his participation in activities of daily living. Documentation also revealed Resident #135 had poor sitting skills with impaired coordination and sensation on his left extremities, and poor postural alignment and control deficits secondary to left sided hemiparesis. Review of the nurses ' notes dated 5/6/11 revealed the resident was found sitting on the floor beside his bed with family member next to him; he slipped while trying to get into bed. No injuries were sustained. Review of the nurses ' notes dated 5/13/11 revealed the resident was found sitting on the floor in front of his wheelchair. The resident stated he was trying to close a box on his nightstand and slid out of his chair. No injuries	F 323	devices to prevent falls, and provide proper positioning in a wheelchair and therapy referrals for positioning. * Corrective measures and systemic changes have been put into place to ensure that the deficient practice will not occur. On a weekly basis, the DON, ADON, QA nurse, and MDS nurses will review all new admissions and residents who have had a fall during the previous week. These residents will be evaluated for further positioning devices to prevent falls and provide proper positioning. Devices will be obtained and implemented as necessary. Therapy will be notified for assistance with positioning devices as needed. Further inservices will be done if necessary. * The facility will monitor its performance to make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 were sustained. According to the 5/13/11 incident report completed by Nurse #1, the resident was sitting in his wheelchair in front of his nightstand, he was trying to close a box on his nightstand, the chair was not close enough and the resident slipped out of his wheelchair landing on the floor. Nurse # 1 found the resident. No injuries were sustained. Personal pad alarms were placed on the chair and bed for this resident. Interview with Nurse #1 on 5/25/11 at 11:00 AM who found the resident when he had fallen on 5/13/11, she stated " I was returning from lunch when I heard him call out and I saw him sitting on the floor to the left of his wheelchair. He stated ' I was trying to put something in this box. ' He needs extensive assistance with transfers and the lift is used now due to his left sided weakness. " Review of the nurses ' notes dated 5/20/11 revealed NA #2 was getting the resident ready for bed, the resident slid out of his wheelchair and landed on the floor sustaining a skin tear to his right elbow and bumped his head. According to the incident report for the fall on 05/20/11, completed by Nurse #2, NA #2 was assisting the resident getting him dressed for bed, NA #2 stated " His right foot was in the lift and she was pulling his shirt off and he fell out of the wheelchair. The resident stated he hit his head, NA #2 confirmed. He sustained a skin tear to his right elbow. First aid to the elbow was done and neuro checks were implemented as per facility policy. "	F 323	sure that solutions are sustained. On a weekly basis, the QA nurse will complete a log of positioning devices that have been deemed necessary for residents to insure that devises are in place and effective. The DON will review this log and report the results quarterly at the Quality Assurance Committee Meeting. The facility will monitor the use of positioning devices for at least two quarters (Quality Assurance Committee Meeting October 26, 2011). At the end of those quarters, the facility will evaluate its performance and determine if continued monitoring is indicated. * The corrective action date will be June 24, 2011.	6/24/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 During an interview with NA #2 on 5/24/11 at 3:40 PM recounted the incident that occurred on 5/20/11, she stated " the resident was in his wheelchair and the lift was off to the right side of the resident, she used it to hang his urinary drainage bag on while she assisted the resident to undress. The resident was sitting in his wheelchair, and he was trying to remove his shirt, so he raised his right arm over his head and grabbed the shirt, I was standing behind him on the right side to help remove his shirt and he lost his balance and slid out of wheelchair. " She continued, " His right foot was on the lift, he was bracing himself. When he slid, he slid off the chair to the left side he could not stop himself; he landed against the door and wall and got a skin tear on his left forearm and he hit the back of his head slightly against the door. He immediately said ' I am okay. ' After he landed on the floor, I pulled the lift and wheelchair out of the way, and I went and got the Nurse to assess him and the Nursing Supervisor and another NA got him back to bed with me. " " We (the NAs) use two people when we use the lift, so I did not put him of the lift yet because I was alone. " During an interview on 5/24/11 at 3:48 PM Nurse #2 revealed NA #2 told her his right foot was on the lift and he fell to the left, he did not complain of pain. She further indicated she assessed him and since he hit his head she started neuro checks according to the facility policy. She also indicated that she coached NA #2 to try to do things one at a time, the area was too crowded. Nurse #2 stated " before this fall he was a one person assist, but now we use two people with all lifts and transfers for this man. That night I (Nurse #2) wrote a note to inform all staff that he	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 required two people for all transfers. " " I inform the NAs if there is ever a change in a resident ' s care needs. " She indicated she did not realize his positioning was the issue, and her coaching for the NA did not include that the NA should protect his weak side. During an interview with Nurse #2 and NA #2 on 5/26/11 at 4:45 PM revealed a different account of where the NA was standing, she stated she was standing behind the resident on his left side helping him remove his shirt and he slid off the left side of the wheelchair. The NA #2 stated " I think he lost his balance and fell to the left and just slid out of the chair. I was behind him so I could not catch him. " Nurse #2 and NA #2 agreed the NA should have been standing in front of him on the left side to protect him from falling since it was his weak side. During an interview with the resident on 5/24/11 at 11:13 AM he stated " I feel this seat cushion help to contribute to my fall the other night. " He stated " the NA (NA #2) was getting me ready to go to the bathroom; I think she was trying to get me on the lift. I was sitting in my wheelchair. My left arm was not in the cradle because I was taking my shirt off. I don ' t know why she (NA #2) was behind me and tried to help me take off my shirt because I can get my shirt off myself. I fell and landed on the floor and hit my head and scratched my left elbow. " A telephone interview was conducted at 3:00 PM on 5/26/11 with the responsible party (RP) who received the call on 5/20/11 from Nurse #2 to report the incident. She stated " I received a call and the nurse (nurse #2) told me ' someone was	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 trying to use the lift with your father and he slipped out of it and hit his head, he was fine, he just got a skin tear on his arm. ' " She expressed her concern that he fell to the left side since that was his weak side. Review of the care plan dated 5/22/11 revealed a problem of falls due to impaired mobility s/p (status post) CVA and had a recent fall. The interventions included assist with transfers/mobility/toileting, appropriate footwear for transfers, Pad alarm, falls risk assessment completed quarterly, resident required assistance with ADL (activities of daily living) mobility, toileting, dressing and transfers. During an interview with the MDS nurse on 5/26/11 at 4:45 PM revealed there should be specific information regarding the resident ' s left sided weakness. There also should be an intervention stating how many people were needed to transfer this resident and that a lift was to be used. She also revealed the care plan was updated every 21 days or as frequently as needed especially if a lift was now being used for the residents to transfer. She stated " I am not the nurse assigned to complete the care plan for this resident. " An interview with the NA #1 on 5/24/11 at 10:15 AM revealed this resident required two people to use the lift to transfer him. He sat in the wheelchair most of the day. He tried to reposition himself in the wheelchair while he was sitting, he was able to propel himself, but slipped in the chair and " we need to help him sit up in the wheel chair. We need to help reposition him in the wheelchair often. He tends to lean to the left. "	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 During an Interview with NA #1 on 5/25/11 at 11:20 AM she stated " they (staff) use a lift or 2 people to transfer the resident from the bed to wheelchair or bed to toilet, because of his weak left side. " During an observation of the resident on 5/24/11 at 11:00 AM he was sitting in his wheelchair, leaning to his left side, he was observed attempting to frequently reposition himself from leaning to the left side by pushing himself back into the wheelchair seat to sit upright in the wheelchair using his right leg. He was seated on a square cushion with a folded cloth on top on the seat cushion, but he was never able to sit himself up straight in the wheelchair, the cushion kept sliding forward as the resident attempted to sit up straight. His left arm was resting next to his body in the wheelchair. There was an arm trough cradle on the left arm of the wheelchair. He also was observed lifting his left leg with his right arm several times to put it back on the raised left leg rest. During an interview with the resident on 5/24/11 at 11:00 AM he stated " my arm keeps slipping off this thing (left arm trough cradle), and I keep sliding down in my seat. " He revealed he attended PT (physical therapy) everyday and feels he was getting stronger. During an observation of the resident on 5/25/11 at 10:45 AM the resident was slouched to the left side in his wheelchair with his legs on the floor, he was attempting to reposition himself by pushing himself up into a straightened sitting position, using his right leg and right hand. His	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 buttock was noted to be positioned on the end of the seat cushion, causing him to lean back and rest his shoulders against the back of the wheelchair, a gap was noted between the back end of the seat cushion and the wheelchair back (measured approximately 31/2 inches). The square seat cushion with a folded cloth on top of the seat cushion was noted to slide back and forth when the resident attempted to reposition himself in the wheelchair. His left arm was noted to be resting on his left leg, not on the arm trough cradle provided to prevent his arm from drooping. The resident stated " this cushion probably contributed to my fall the other night. " " I slid off my wheelchair and I landed against the wall and bumped my head on the door after I landed on the floor. " During an observation of the resident on 5/26/11 at 11:23 AM he was sitting on a square seat cushion with a folded cloth on top of it in his wheelchair. He was seated at the front edge of the cushion in a reclined position with his shoulders resting on the back of the chair; there was a gap of 3 inches noted between the back edge of the cushion and the back of the wheelchair. He was observed to try to sit up straight in the chair by pushing himself back in the chair with his right foot on the floor. His left arm was noted to be on his lap. He attempted several times to position his left arm in the left arm cradle trough using his right hand, because it slipped off the cradle trough when he tried to readjust his sitting position. He stated " it is uncomfortable for me to sit in the wheelchair; I slide off this seat cushion very easily when I am trying to get comfortable and sit up straight. "	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 An interview with the PT and OT was conducted on 5/25/11 at 2:15 PM. The OT indicated he assessed the resident on 5/4/11, he can place the resident in a wheelchair, and he (the resident) could self propel using his right foot and right arm for steering. He had poor postural strength due to a stroke, so this wheelchair allowed him to develop better posture and endurance by sitting up in the chair and increasing his participation in activities. He indicated the resident has left sided weakness and tended to lean to the left and he (OT) was trying to correct this with the aid of the chair cushion and left arm trough cradle since his left arm was flaccid and had the tendency to develop edema. His therapy was geared towards concentrating on his posture and positioning in the wheelchair and during transfers and bed mobility. The OT stated " we reviewed with the day staff (NA and Nurses) the proper positioning of the resident to protect the resident during transfers and repositioning. The staff should position themselves on his weak side (left) to add support and assistance. Our main focus was on positioning and safety while in the wheelchair and transfers. " During a meeting with the resident, OT and a family member on 5/26/11 at 2:30 PM the resident stated " I feel like I am slipping out of this chair all the time. " The OT agreed to change to a wedge cushion and explained to the resident this wedge cushion would help him to sit back in a better position in the wheelchair instead of feeling like he was slipping forward. He also agreed to adjust the left arm support and speak with the nurses to change his out of bed schedule, so he could rest more frequently until he was able to build up his strength and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 endurance for sitting up in the chair. The resident and family member expressed their agreement and pleasure with the ideas they discussed. The OT took the wheelchair and agreed to return it that afternoon after he changed the cushion and adjusted the left arm support. During an interview on 5/26/11 at 2:50 PM with a family member, she indicated she was concerned because his left side was useless due to the stroke and he tended to lean to that side of the wheelchair and she was afraid he was going to fall again. The family member stated " I hope the OT ' s suggestions and changes will help keep him safer in the wheelchair. " She also indicated how upset they (her family) were when they got the call that he fell again in such a short time being here. On 5/26/11 at 3:34 PM the OT stated "I put a new wedge seat cushion on the wheelchair, which will help him to sit up with better positioning easier and also readjusted the left arm cradle. He (OT) also stated he spoke with the nurse to develop a new schedule for the nursing staff to get the resident to be able to get back and forth into the bed more frequently. He will rest in bed and will be able to stay in the chair in better position longer as he develops better posture and endurance. On 5/26/11 at 4:14 PM during an interview with MDS Nurse #2 revealed she obtained the information for the care plans and the MDS from many sources. One of the sources was the ADL tracker completed by the nurse during the look back period. Care Plans were generally updated quarterly, changes can be made as necessary	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 too. His care plan was just due this week. The MDS Nurse stated :we generally do not list each fall on the care plans, I am aware he had 2 falls previous to the 5/20/11 fall, I know he had pad alarms added to care plan. " She further reviewed the care plan and indicated that it was listed under interventions that he required assistance with care, dressing and transfers, bed mobility and toileting. The MDS Nurse stated " we do not indicate if two persons are needed for assistance unless it is specified for safety. She did not receive an order stating he required two person assists for safety during transfers. She also indicated that the problem list indicated he had a CVA, but did not specify he has left sided weakness, this should have been indicated. During an interview with the Director of Nursing on 5/26/11 at 5:18 PM she indicated NA #2 had the resident in his wheelchair in his room; she was getting him ready for bed. She had put the lift in room, and placed the drainage bag on the lift, NA #2 was standing on his right side behind him helping pull off his shirt and he slid off the wheelchair toward his left and landed on the floor. He bumped his head after the fall. She went and got help from the nursing supervisor, the nurse assessed him got him straightened out (got him into bed using the lift), worked on skin tear. Nurse #2 called the RP and left word for the doctor. The DON indicated she felt he (the resident) was being impulsive. The staff now tried to deal with him one task at a time; she thought NA was smart to get the bag and tubing out of the way by placing it on the lift. Her expectation would have been to have the NA work in front of a resident with a weakness so she can make sure the resident was safe and have her staff to have	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	345235		05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	100 WADE COBLE DRIVE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 increase caution with his (Resident #135) care and remind him to be aware of what he was doing, and re educated him to watch his weak left side. She revealed he normally transferred really well when you talk him through it, but he was impulsive. She stated " we are developing a care plan to deal with his impulsiveness since this is not the first occurrence. " She stated " the nurse requested an order from the physician to change his seat cushion to a wedge cushion this afternoon. " He currently had a pad alarm on his wheelchair and bed. She further indicated her expectation of her staff with a resident with left sided weakness who has slid from his wheelchair twice would be to would be to keep him safe, using bolsters, and assess the effectiveness of each intervention. She stated PT continues to work with him too.	F 323		