

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

PRINTED: 07/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
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NAME OF PROVIDER OR SUPPLIER LENOIR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 322 NUWAY CIRCLE LENOIR, NC 28645
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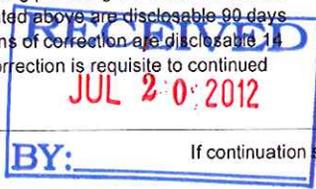
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F 312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews the facility staff failed to use proper incontinence care technique for three (3) of seven (7) residents (Residents #113, #4, and #36) and provide nail care to one (1) of two (2) residents. Resident (#75).</p> <p>Findings are:</p> <p>A review of a facility policy titled "Perineal/Incontinent Care" with a revised date of 2/12/12 indicated a policy statement "Perineal/Incontinent care is washing of the genital and rectal areas of the body and should be done during the daily bath, during incontinent episodes and as needed. The procedure indicated to "Use one hand to grasp edge of washcloth or wipe. Using a second hand, separate the labia and wash using disposable wipes, using a clean wipe for each side and then another for the middle always using downward strokes. If using a washcloth use a separate part of the cloth for each stroke."</p> <p>1. Resident #113 was readmitted to the facility on 9/7/11 with diagnoses including dementia, muscle weakness, anxiety, and failure to thrive.</p>	F 312	<p><i>F 312</i> <i>This plan of correction is the facility's credible allegation of compliance.</i></p> <ul style="list-style-type: none"> ●DON or designee instructed nursing assistants #3, #4, #6 on proper incontinent care and they returned a demonstration on 06/26 and 06/28. Residents #113, #4 and #36 received proper incontinent care on 06/26 and 06/28. ●All current incontinent residents were observed for proper incontinent care by DON and ADON June 26th to June 29th was found incompliance. ●Nursing assistants will be in-serviced on proper incontinent care by DON and ADON by July 27th. ●Quality improvement monitoring will be done by ADON to ensure residents continue to receive proper incontinent care.as follows : ADON will observe two nursing assistants 4x weekly 8 weeks, then weekly for nine months. New nursing assistants will be instructed by ADON. ● The ADON will prepare a summary of monitoring for presentation during the monthly QA Committee Meeting times two months where the success of the plan will be reported and decisions to change it when necessary will be discussed. <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by provisions of state and federal law.</i></p>	08/03/2012
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nancy Meene</i>	TITLE LWHA	(X6) DATE 7/19/12
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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.

original signature 7/12/12 mh



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F 312	<p>Continued From page 1</p> <p>The most recent comprehensive Minimum Data Set (MDS), a significant change, dated 9/18/11 coded Resident #113 with moderate impairment of cognition and required total assistance with toileting and hygiene.</p> <p>The Comprehensive Area Assessment (CAA) for activities of daily living skills (ADLs) dated 9/22/11 stated Resident #113 needed the assistance of one staff for ADLs and was dependent on staff for hygiene.</p> <p>On 6/21/12 at 9:30 AM nursing assistant (NA) #3 was observed performing incontinent care for Resident #113. Resident #113 was incontinent of a moderate amount of urine and a small amount of formed stool. NA #3 applied gloves and assembled supplies. NA #3 had a towel wet on one end and dry on the other end. NA #3 applied periwash to the wet end of the towel. NA #3 loosened the soiled adult brief and tucked the top portion under the resident. NA #3 used the wet end of the towel and cleansed the perineal area from back to front three (3) times using the same area of the wet towel, then dried the area with the dry end of the towel.</p> <p>On 6/21/12 at 9:45 AM NA #3 was interviewed and revealed she performed perineal care from back to front because the resident did not like to straighten out her legs.</p> <p>On 6/21/12 at 10:30 AM an interview with the Assistant Director of Nursing (ADON) revealed she expected the NA to clean female residents from front to back.</p>	F 312			

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F 312	<p>Continued From page 2</p> <p>2. Resident # 4 was admitted to the facility on 9/17/75 with diagnoses including cerebral palsy, profound intellectual disability, and urinary incontinence. Resident # 4's quarterly Minimum Data Set (MDS) completed on 4/2/12 assessed the resident to be totally dependant on staff for toileting and required extensive assistance of two staff for activities of daily living including bathing, toileting and hygiene.</p> <p>On 6/21/12 incontinence and perineal care of Resident # 4 was observed. At 9:04 AM Nursing Assistant # 4 (NA # 4) removed a soiled adult disposable brief from the resident who was laying on her bed. NA # 4 the placed the used brief in a plastic bag held by the Assistant Director of Nursing (ADON). NA # 4 then proceeded to use a large bath towel with warm water and periwash cleaner to clean Resident # 4's perineum. NA # 4 wiped in a downward direction with separate areas of the towel over the perineum, Observations during care revealed NA # 4 used one hand to control the towel and clean the resident and the other hand was used to hold the residents legs apart. Observations further revealed NA # 4 also wiped in a downward direction in both inguinal folds. NA # 4 did not separate the labia to perform hygiene to this area.</p> <p>After drying Resident # 4's perineum with the dry end of the bath towel NA #4 placed the towel into another bag held by the ADON. NA # 4 then replaced a clean adult disposable brief, and assisted resident back to her wheelchair with the assistance of the ADON.</p> <p>At the time, care was being concluded NA # 4 was asked about separating the labia while</p>	F 312		

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F 312	<p>Continued From page 3</p> <p>performing care. NA # 4 indicated it was difficult to hold Resident #4's legs apart and provide incontinence care when providing care alone. She further indicated usually two people provided care for Resident # 4.</p> <p>3. Resident #36 was admitted with diagnoses including kidney disease, heart disease, hypertension, depression and anxiety. The most recent quarterly Minimum Data Set (MDS) dated 5/3/12 indicated impairment in short and long term memory and moderate impairment in cognition for daily decision making. The MDS also indicated Resident #36 required extensive assistance by staff for personal hygiene and dressing and was always incontinent of bladder and bowel.</p> <p>A review of a care plan that was not dated with a problem statement of Altered Urinary Elimination indicated Resident #36 had bladder and bowel incontinence. The approaches were staff should report any signs or symptoms of a urinary tract infection such as frequency, urgency, blood in urine, painful urination or increased confusion to the nurse; use incontinent briefs on resident as needed and give perineal care when the resident was incontinent.</p> <p>A review of a facility document titled "Bladder Incontinence Evaluation" and dated 5/16/11 indicated Resident #36 was confused, urinates often in small amounts, doesn't alert staff when she needed to urinate and had been on a scheduled toileting program in the past but was unable to participate and was no longer on a toileting program.</p>	F 312			

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F 312	Continued From page 4 During an observation of incontinence care on 6/20/12 at 9:35 AM Nursing Assistant (NA) #6 removed the top sheet and Resident #36 was lying on an incontinence pad but was not wearing a brief. The pad was saturated with urine and a large brown ring extended to the edges of the pad and a small amount of stool was on the resident's left (L) buttock. NA # 6 applied a perineal cleanser to a towel and pushed it down between Resident #36's right (R) and (L) groin three (3) times but did not separate the labia to clean her. NA #6 placed a clean brief and clothing on Resident #36 and transferred her from her bed to a geri-chair. During an interview on 6/20/12 at 9:45 AM with NA #6 she stated it was her usual technique to push the moistened towel with perineal cleanser down through each groin and pull the towel out from the back. She stated she sometimes separated the labia to clean inside but she did not separate the labia because she thought it was painful for the resident. During an interview on 6/21/12 at 10:17 AM the Assistant Director of Nursing (ADON) stated staff could use towels with the perineal cleanser for perineal care and they should always wipe from front to back and should separate the labia to make sure the resident was clean. During an interview on 6/21/12 at 12:23 PM the Director of Nursing (DON) stated it was her expectation for nursing staff to follow the policy for incontinence care to ensure the resident was clean.	F 312			

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F 312	Continued From page 5 4. Resident #75 was admitted with diagnoses including depression and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 4/19/12 indicated impairment in short and long term memory and moderate impairment in cognition for daily decision making. The MDS also indicated Resident #75 required extensive assistance by staff for personal hygiene and dressing. During an observation on 6/18/12 at 11:43 AM Resident #75 was sitting in her wheelchair in her room and her fingernails on both hands were long and uneven with broken nails on the index finger on her left (L) hand and the middle finger on her right (R) hand and chipped nail polish on every fingernail. During an observation on 6/20/12 at 8:22 AM Resident #75 was sitting up in her wheelchair eating breakfast. The fingernails on both hands were long and uneven with broken nails on the index finger on her left (L) hand and the middle finger on her right (R) hand and chipped nail polish on every fingernail. During an observation on 6/21/12 at 8:55 AM Resident #75 was sitting in her wheelchair in her room. The fingernails on both hands were long and uneven with broken nails on the index finger on her left (L) hand and the middle finger on her right (R) hand and chipped nail polish on every fingernail. During an interview on 6/21/12 at 9:01 AM Resident #75 stated she liked to have her nails done but she could not remember when they	F 312		

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F 312	Continued From page 6 were last cleaned or trimmed. She further stated they had not been polished for awhile. During an interview on 6/21/12 at 10:37 AM Nursing Assistant (NA) #4 stated Resident #75 was cooperative during personal care and had a shower twice a week. She explained staff was supposed to do nail care for residents during their bath or shower and they had clippers and orange sticks available to use. NA #4 verified Resident #75's nails were long and uneven and the nail polish was chipped and stated she thought her nails needed to be trimmed and cleaned underneath the nails. During an interview with the MDS Coordinator on 6/21/12 at 10:06 AM she verified Resident #75 had a shower twice each week on Monday and Thursday. During an interview on 6/21/12 at 10:18 AM the Assistant Director of Nurses (ADON) stated if nursing staff saw a resident with dirty or broken fingernails they should clean them and trim them during their shower or bath. During an interview on 6/21/12 at 12:23 PM the Director of Nursing (DON) stated it was her expectation nursing staff should check resident's finger nails when they made their rounds to make sure resident's nails were kept clean and if their finger nails were broken or jagged they should be trimmed.	F 312	F 312 <i>This plan of correction is the facility's credible allegation of compliance.</i> ● Resident Number 75 was provided nail care on June 21, 2012 by activity department. ● Hall ambassadors checked all residents to assure all issues with nails were in Compliance by June 29 th . ● Activity Department and Nursing assistants will be in-serviced on nail care by ADON by July 26 th . Sheet will be placed in soiled utility room for staff to list if nail polish noted in need to be replaced. Activity Director or assistant will check list two times weekly and remove polish and replace as needed. ● Ambassadors will check four residents weekly Times eight weeks and report if nail care is needed And will follow up to assure it is done if not they will report to DON or ADON. Ambassadors will continue to do checks past eight weeks to assure continued compliance. ● The Ambassadors will prepare a summary of monitoring for presentation during the monthly QA Committee Meeting times two months where the success of the plan will be reported and decisions to change it when necessary will be discussed. <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by provisions of state and federal law.</i>	08/03/2012
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	F 323		

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F 323	Continued From page 7 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 and staff interviews, the facility failed to consistently implement and re-evaluate the use of a tab alarm after identifying one (1) of one (1) sampled resident regularly removed the tab alarm. Resident #146. The findings were: Resident #146 was admitted to the facility on 3/31/12 with diagnosis of a history of falls, osteoporosis, muscle weakness, tachycardia, and insomnia. Review of the fall investigations revealed Resident #146 fell on 4/1/12 at 3:00 PM when she transferred herself from the wheelchair to the bed. There were no injuries. She began receiving Occupational Therapy (OT) and Physical Therapy (PT) on 4/2/12 five times a week. Review of the fall investigations revealed she again fell on 4/4/12 at 11:15 AM when she transferred herself to the wheelchair. She received no injuries. The admission Minimum Data Set (MDS) dated 4/7/12 coded Resident #146 as being cognitively intact (scoring a 13 out of a possible 15) and requiring extensive assistance with bed mobility, transfers, toileting, and hygiene. She required	F 323	F 323 <i>This plan of correction is the facilities credible allegation of compliance.</i> ●The personal care alarm for wheelchair for resident number 146 was reevaluated by DON and removed and a seat alarm was placed in wheelchair on June 21 st and alarm in bed in place and attached. ● All residents with personal care alarms were audited and use of alarms were re-evaluated by DON on June 22, 2012. ●Nursing assistants and Nurses will be in-serviced on personal care alarms by ADON by July 27 th , 2012. Licensed Nursing staff will check alarms every shift to assure proper functioning, placement and document on MAR. ●Ambassadors will check tag alarms five times weekly for six weeks to assure in place and functioning. ● The Ambassadors will prepare a summary of monitoring for presentation during the monthly QA Committee Meeting times two months. If alarms are not working as intended then other options to alarms will be discussed and decisions to change if necessary. <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by provisions of state and federal law.</i>	08/03/2012

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F 323	<p>Continued From page 8</p> <p>limited assistance with ambulation and had falls prior to admission to the facility and falls since being admitted to the facility. Resident #146 was coded as receiving OT and PT.</p> <p>The Care Assessment Area Summary (CAAS) dated 4/9/12 relating to falls described Resident #146 as having fallen in her apartment prior to admission and since admission. The CAAS stated she was receiving PT and OT, required contact guard with ambulation, and was restraint free. The CAAS indicated a care plan would be developed.</p> <p>On 4/9/12 the physician ordered a personal alarm (pull apart/ "tab") device to be applied to Resident #146 while in the wheelchair and while in bed.</p> <p>A care plan developed 4/17/12, which addressed Resident #146's history of falls, stated she used a walker for ambulation and used a wheelchair for long distances. The care plan also stated a personal alarm device was used in the wheelchair and in bed.</p> <p>A nursing note dated 4/23/12 stated Resident #146 removed the tab alarm and placed the alarm under her pillow.</p> <p>Nursing notes dated 5/12/12 at 9:50 PM noted Resident #146 had removed the tab alarm from her shirt, hooked it to the bed sheet and fell from her wheelchair. Review of the fall investigations revealed on 5/12/12 at 9:50 PM, Resident #146 removed the alarm and fell going to the bathroom while wearing plain socks. The falls care plan was updated on 5/12/12 with the additional intervention to encourage her to request</p>	F 323			

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F 323	<p>Continued From page 9 assistance to the toilet.</p> <p>Nursing notes dated 5/21/12 revealed Resident #146 was observed having removed her tab alarm.</p> <p>OT discharged Resident #146 from therapy on 5/28/12 having met her maximum potential with notable increased strength and endurance. PT discharged the resident on 5/29/12. The PT discharge summary noted she was able to transfer with one care giver assist with verbal cues for safety and she was able to ambulate with the rolling walker and verbal cues to increase her step length and walk into the walker. Resident #146 was then referred to restorative care on 5/29/12 to assist with bilateral lower extremity exercises and ambulation with the rolling walker.</p> <p>Per the nursing notes, on 6/9/12 at 1:30 AM Resident #146 fell going to the bathroom. The tab alarm had sounded and Resident #146 was noted to be wearing plain socks. The falls care plan was updated on 6/9/12 to remind the resident to request assistance with toileting especially at night and to wear shoes.</p> <p>Per the nursing notes, on 6/12/12 at 7:00 PM, Resident #146's alarm sounded and she was found on the floor. She had been transferring from the wheelchair. She did have shoes and socks on. The care plan was updated on 6/12/12 to check for a possible urinary tract infection.</p> <p>Nursing notes dated 6/14/12 at 7:30 PM noted the alarm sounded and the resident was found sitting on the floor in front of the bathroom door.</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>The nurse aide had just returned the resident from the shower. The care plan was updated 6/14/12 to include the antibiotic treatment of a urinary tract infection.</p> <p>Resident #146 exhibited some short term memory problems i.e. not knowing how long she had been in the facility on 6/19/12 at 3:13 PM. She did not have a tabs alarm in place during the following observations:</p> <p>*6/19/12 at 3:13 PM: The resident was laying across the made bed, wearing shoes and socks. A tab alarm box was attached to her head board but not clipped to the resident. Another alarm was noted on the back of the wheelchair, which was next to the bed, but the alarm on the wheelchair was not clipped to her.</p> <p>*6/19/12 at 3:38 PM: The tab alarm was not attached to the resident as the clip was clipped to the string on the back of the head board. The resident was half sitting, with her feet off the edge of the bed working on a word search puzzle. She stated at this time, she had falls which was why there was an alarm on the wheelchair.</p> <p>*6/20/12 at 9:42 AM: The resident was dressed with shoes and socks, asleep on top of the bed covers. The tab alarms were observed on both the wheelchair and the head board of the bed, however, neither were attached to the resident.</p> <p>*6/20/12 at 10:59 AM: Resident #146 was in the wheelchair with no alarm wheeling away from the bathroom door. She stated she had just gone to the bathroom. She stated she put the call light on but no one came so she took herself. There was</p>	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER LENOIR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 322 NUWAY CIRCLE LENOIR, NC 28645		
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F 323	<p>Continued From page 11</p> <p>no call light activated at this time. Within a couple of minutes, Resident #146 transferred herself from the wheelchair to the bed. No alarm sounded as no alarm was attached.</p> <p>*6/20/12 at 12:12 PM: The resident was up in the wheelchair eating her noon meal. No tab alarm was attached to the resident.</p> <p>*6/20/12 at 2:10 PM: the resident was observed lying on the made bed, wearing shoes and socks but with no tab alarm attached to her.</p> <p>On 6/20/12 at 2:13 PM, Nurse Aide (NA) #5 stated that since Resident #146 had received therapy, the resident thought she could do more for herself. NA #5 stated staff encourage her to keep the alarm on but she took it off. NA #5 further stated that she had not assisted the resident to bed after lunch. NA #5 stated she saw Resident #146 in bed but did not check to ensure the personal alarm was attached to the resident. When asked if she had reported to the nurses that Resident #146 removed her tab alarm, she replied that all the nurses knew it as they also encouraged the resident to leave it attached.</p> <p>On 6/20/12 at 2:29 PM, Licensed Nurse (LN) #2 stated staff were aware that Resident #146 removed her tab alarms and that staff encouraged and reminded the resident to keep the alarm attached. LN #2 further stated Resident #146 had been worse about keeping the alarm attached in the past few days because she had more confusion due to a urinary tract infection.</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>On 6/20/12 at 3:14 PM interview with the Director of Nursing (DON) revealed Resident #146 was currently not on a toileting plan and staff suspected the resident's last two falls were due to increase in confusion with the urinary tract infection. The DON stated she was aware the resident sometimes removed the tab alarm but was not aware as to how often she removed it. She stated they had not tried an alternative type of alarm.</p> <p>On 6/21/10 at 11:03 AM an interview with the Assistant Director of Nursing (ADON) revealed Resident #146's falls were discussed in the morning meetings and that she was aware the resident removed her tab alarm at times. She could not say what was implemented when staff discussed the resident's removal of the tab alarm. Further interview with the ADON on 6/21/12 at 11:05 AM revealed the staff were encouraged to check to make sure the alarm was attached to the resident. This was to be done whenever they were in the room and at least during their every two hour rounds.</p>	F 323			