

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

PRINTED: 05/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345275</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINGS MOUNTAIN HOSPITAL SNF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>705 W KING ST KINGS MOUNTAIN, NC 28086</b>
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(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	<p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and medical record review, the facility failed to ensure one (1) of four (4) residents was transferred according to therapy recommendations, resulting in a fall (Resident #3).</p> <p>The findings are:</p> <p>Resident #3 was admitted to the facility on 04/20/11 with a diagnosis of a fracture of the right femur. Review of her medical record revealed she had fallen at home and broken her hip, had surgery, and had come to the facility for rehabilitation therapy.</p> <p>On 05/03/11 at 10:30 a.m. the resident was observed ambulating in her room toward a chair which she sat in, assisted by the Physical Therapy Assistant (PTA). The resident was wearing a gait belt around her waist which the PTA was holding on to during the ambulation. The resident's right foot did not touch the floor during the ambulation as she hopped on her left leg only, using a walker for support.</p>	F 323	<p>Corrective action taken for Resident # 3 for whom deficiencies were related is as follows:</p> <p>Transfer instructions for Resident # 3 as well as other residents were reviewed and discussed during interdisciplinary meetings to ensure continued communication, effective May 4, 2011. Interdisciplinary meeting to continue as a permanent process.</p> <p>All staff performing transfers for Resident # 3 were trained in use of the gait belt by therapy staff beginning on May 3, 2011.</p> <p>Because of multiple falls for Resident # 3, two people were assigned to perform transfers effective May 3, 2011.</p> <p>Resident # 3 was discharged May 18, 2011. No further falls occurred after May 3, 2011.</p> <p>Corrective action plan and process changes were developed to ensure that the deficient practice will not re-occur.</p> <p>Therapy staff provided an in-service to all SNF clinical staff for education of proper transfer techniques and the use of gait belts. Informal education was started on May 3, 2011, for the staff working with resident #3 and other applicable residents and continued through the month of May. All SNF clinical staff were educated by June 1, 2011.</p>	6-1-2011 per TC E. J. Greenlee on 6/1/11 9 n

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  ✓ <i>Brian Gray</i>	TITLE  ✓ CEO	(X6) DATE  ✓ 6-3-11
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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 the institution's 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 Date: 5-24-11

RECEIVED  
JUN 6 2011  
BY: *ORA*

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F 323	Continued From page 1  On 05/03/11 at 1:00 p.m., Resident #3, who was considered alert and oriented and reliable for interview by the facility staff, was interviewed. She stated that after her therapy session today, her nurse and nursing assistant had assisted her to ambulate to the bathroom using her walker. She stated one staff held her under each arm, but they did not use a gait belt to hold on to her. Resident #3 stated her left knee buckled as she turned in the bathroom and she fell to both knees. She denied any injury. She stated she has to hop on her left leg only as she is not supposed to put any weight on her right leg yet. The resident also stated she had fallen while being assisted by staff to the bathroom last week.  On 05/03/11 at 1:20 p.m., the PTA who had worked with Resident #3 was interviewed. She stated the resident ambulated with staff assist to the bathroom using her walker and hopping on her left leg as she was not yet cleared for weight bearing on the right leg. She stated she had been doing well ambulating when she was first admitted, but had fallen or been lowered to the ground three times recently, which included the fall today. The PTA stated the first time was with nursing staff, and the second time was with the PTA last week who was using a gait belt and had to lower the resident to the floor. She stated that after the second fall she told the nurses and nursing assistants who were at the nursing station that if they ambulated the resident to the bathroom the resident needed to use the walker, with two staff members using contact guard assist with a gait belt for safety. She told the staff that she had left a gait belt in the resident's room for their use with the resident. She was not sure	F 323	Written policy for gait belt transfer was developed and endorsed on May 23, 2011, to reflect new process for gait training.  Proper transfer techniques were incorporated into the SNF new employee orientation program for any new employee starting after May 4, 2011. One new employee received education on May 23, 2011.  All residents are reviewed for safe transfer techniques during the interdisciplinary meeting and special instructions provided by therapists effective May 4, 2011.  Review of all residents was completed on May 4, 2011, to identify the need for proper transfer techniques. One resident was identified other than Resident #3. This resident was discussed during interdisciplinary meeting with documentation on stand-up meeting log.  Communication book (stand-up meeting log) was enhanced to include specific therapy instructions related to safe transfer techniques for individual residents on May 4, 2011. This book will be placed at nursing station for reference by all staff.	

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F 323	<p>Continued From page 2 if her recommendation was passed along to all staff.</p> <p>The PTA further stated in the interview that Nursing Assistant (NA) #1 came to get her today and told her the resident had fallen during ambulation to the bathroom while being assisted by NA #1 and Licensed Nurse (LN) #2. The PTA stated when she entered the room the resident was on her knees in the bathroom and was not wearing a gait belt. She stated she expected nursing staff to ambulate the resident per her recommendation, using the walker with two staff members using the gait belt.</p> <p>On 05/03/11 at 1:46 p.m. NA #1 was interviewed. She stated that before lunch Resident #3 needed to go to the bathroom, so she asked LN #1 for assistance with the transfer and ambulation because she knew the resident had fallen twice before while ambulating. She stated one staff was on each side of the resident but they did not use a gait belt. NA #1 stated that the resident went to her knees when she was trying to turn around in the bathroom. She stated that the type of transfer used for any resident is passed along in shift report, but is not written down. She also stated that there is a daily meeting with the Occupational Therapist in which transfers for specific residents are discussed. She further stated that she had not been trained by the facility in the use of gait belts and was not aware of anyone telling her to use a gait belt with this resident.</p> <p>On 05/03/11 at 2:05 p.m. LN #1 was interviewed. She reported that she and NA #1 had ambulated Resident #3 to the bathroom before lunch and the</p>	F 323	<p>Performance monitoring: Audits will be performed by the Director of Nursing or designee on all residents requiring two assists or gait belt usage on at least a weekly basis. Audit will be conducted using a QA tool. Audit tool developed and implemented on May 4, 2011.</p> <p>Results will be reviewed by the DON and reported at Monthly Core Quality Meetings beginning in June, 2011, for a minimum of three months. The Community Trustee Council Quality Committee will have a monthly update as well commencing July, 2011, for three months and will assess continued reports based on compliance.</p>		

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F 323	Continued From page 3 resident had fallen to her knees as she was turning in the bathroom. She stated she and NA #1 were on both sides of the resident and she was holding her under her arm, but they were not using a gait belt around the resident. She stated when she started down, NA #1 grabbed the resident around the waist to help lower her to the floor. LN #1 stated the resident was not injured in the fall. LN #1 stated she had not been instructed to use a gait belt with Resident #3 but she wished she had used one now.  On 05/03/11 at 3:21 p.m. the Director of Nursing (DON) was interviewed. She stated that she was not aware of a therapy recommendation for use of a gait belt with this resident, but she stated that she would expect that two staff members would ambulate the resident with contact guard assist due to her previous falls. She stated she would expect the therapy department to keep nursing informed of what kind of transfer to use. She stated that if the therapist recommended use of a gait belt, her staff would need to be trained in proper use of the belt. The DON stated that they needed better communication between the therapy department and nursing and a better way for nursing to know which transfer a resident required.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	All staff members in the Dietary Department were provided an in-service on the Food and Supply Storage Procedure Policy. This policy includes procedures for dating and discarding food for which the expiration date or use-by date has expired, as well as procedures for the proper storage of scoops. On May 5, 2011, the Director and supervisors commenced the process prior to educating their employees. In-service was completed by the Director of Food Service on Friday, May 20, 2011.	6-1-2011 per TC J. Greene on 6/1/11 AM

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F 371	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and documentation review the facility failed to store food items within the use by date and store ingredient scoops properly.  The findings are:  An initial tour of the hospital's kitchen was made on 5/3/11 at 9:40 a.m. with the kitchen's supervisor. Observations made of the kitchen's walk-in-cooler revealed the following food items stored ready for use:  1. sliced roast beef dated 4/22/11 2. a ½ ham shoulder dated 4/24/11  The kitchen supervisor was interviewed at 9:45 a.m. and specified deli meats were good for 7 days after opening and removed the sliced roast beef. She reported the ham was also good for 7 days after it was cooked. She also removed the ham from use.  Also during the initial tour the ingredient bins were observed. The rice bin revealed the bin was partially full of rice and the scoop handle nestled in the rice. The kitchen supervisor and the morning cook were present for the observation and confirmed the scoop was not to be stored inside the bin so that it touched the ingredients. The kitchen supervisor removed the scoop.	F 371	Cooks were assigned the responsibility of daily review of all food items in the walk-in cooler and dry storage for removal of any food prior to the expiration date and for review of proper storage of scoops. Scoop was removed on May 3, 2011; and expired food was discarded on May 3, 2011. All storage areas and cooler were checked for any out-of-date food items. No other items were identified. A permanent food audit review log was created by the Director of Food Services to be completed daily by the cooks. The log will be maintained on the outside of the cooler and dry storage areas. The audits will begin on May 5, 2011.  Performance Monitoring:  The Director of Food Services and/or Supervisor will verify on a daily basis that the process for daily inspection is occurring and policy is being followed, effective May 5, 2011.  Results will be reported at Monthly Core Quality Meetings beginning in June, 2011, for a minimum of three months. The Community Trustee Council Quality Committee will have a monthly update as well commencing July, 2011, for three months and will assess continued reports based on compliance.	

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F 371	<p>Continued From page 5</p> <p>The Food Service Director (FSD) was interviewed on 5/3/11 at 10:10 a.m. and reported he, the kitchen supervisor and the cooks were responsible for daily audits of leftover food to remove all items past the use by date. He stated he was unaware of how long sliced deli meat was good and provided a policy. He also reported that ingredient bin scoops were not to be stored inside the bins with the ingredients.</p> <p>A document titled "Food Storage Chart" not dated specified that "deli meats - pre-sliced and whole" were to be used within 4 days of refrigeration.</p> <p>The FSD offered no explanation why the deli meal items were stored ready for use past the use by date.</p>	F 371		