

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

*Accepted received 2/14/12 in as [unclear]*

PRINTED: 02/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/26/2012
NAME OF PROVIDER OR SUPPLIER  HARBORVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 812 SHEPARD ST MOREHEAD CITY, NC 28557	
(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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interviews, the facility failed to ensure 1 of 9 sampled residents that required assistance with toileting was treated with dignity and respect (resident #128), and failed to serve 1 sampled resident promptly during mealtime (resident #25). Resident # 25 waited for one hour in the dining room while independent residents were eating, and other residents were fed. Findings include:</p> <p>1. The facility policy, entitled Standards of Care for CNAs (certified nursing assistants), undated, read in part: "All residents are to be treated with respect, dignity, and kindness at all times...Residents are to receive care and services to maximize their well being in a competent and respectful manor...Employees are to conduct themselves in a professional manner at all times."</p> <p>Resident #128 was admitted to the facility on 10/20/11 with multiple diagnoses including severe gait ataxia and tremors.</p> <p>Review of the resident's MDS (minimum data set) dated 10/27/11 revealed she was cognitively intact. The MDS indicated she required</p>	F 241	<p>THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.</p> <p>• F:241 <u>ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</u></p> <p>It is Harborview's expectation that all residents will be treated with respect, dignity and kindness. An incident did occur on 11-4-11 with Resident #128. The CNA involved was terminated. Administration and Social Work have visited with Resident #128 to ensure that she is not continuing to experience emotional distress without intervention. The facility Resident Advocate and Social Worker will continue to visit Resident #128 to ensure that her emotional needs as well as her physical needs are met with dignity &amp; respect. Resident #128 will be visited at least 3 times per week for one month, and then monthly for 3 months to ensure compliance has been achieved and sustained.</p> <p>Resident #25 has not waited for his meal while others ate their meal since 01-26-12.</p>	02-22-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Debra Hamilton*

TITLE

*Administrator*

(X6) DATE

*2-14-12*

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 241	Continued From page 1 one-person physical assistance with bed mobility, dressing, eating, personal hygiene, and toilet use. She required two-person physical assistance with transfers. The MDS indicated the resident was continent of bladder and bowel.  Review of the resident's Care Area Assessment dated 10/27/11 read in part "she cannot ambulate safely at present, staff use a wheelchair and extensive assist to take her to the bathroom, she cannot use her right hand to manipulate clothing and must rely on staff to assist."  Review of the resident's care plan dated 12/1/11 revealed problems with severe trunk ataxia and impaired physical mobility. Approaches included provide extensive assistance with transfers and toilet use.  In an interview on 1/24/12 at 12:33PM, the resident stated a nursing assistant (NA#1) had been rude and disrespectful when she asked for assistance to the bathroom. The meal trays were being passed at that time. NA#1 told the resident she had to pass the trays and could not take her to the bathroom. The resident said NA#1 stated "looks like this is going to be a long day for me." When asked how this made her feel, the resident replied "it was heartbreaking, they are supposed to help us." The resident became tearful during the interview. The resident stated she reported the incident to the charge nurse.  Record review revealed a Family/Resident Concern Form, dated 11/4/11, completed for resident #128. The Nature of Concern read in part: "pt (patient) was crying and upset when nurse went in to pt's room. When asked why, pt	F 241	<u>ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:</u>  An in-service will be conducted on 02-16-12 for all staff including nursing staff to re-education and stress the importance of treating each resident with respect and dignity and to re-iterate the facility's standard of treating residents with respect and dignity in personal care and staff to resident interactions and meal service.  On 02-10-12 the facility formed a Dining Committee composed of the CDM, DON, Administrator, Activity Director and two CNAs and had the inaugural meeting. The committee will be charged with the responsibility of overseeing the dining experience for all residents and to develop, implement and oversee a dining program that ensures all residents experience a quality dining experience for all meals. The committee reviewed how food trays are currently delivered, which residents need assistance, which ones are independent and which ones are totally dependent for dining services on the 300 Unit. A plan was devised for tray delivery, resident seating arrangements and staff assistance that will prevent the incident(s) of any resident waiting for their meal while other residents enjoy a meal in their view. An in-service will be held on 02-16-12 to educate staff on the new dining program	

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F 241	<p>Continued From page 2</p> <p>stated "CNA (certified nursing assistant) had told her she could not take her to BR (bathroom), trays were coming up and she could use the bed pan. CNA stated "I have to get these trays out before they take them from us." When pt asked again CNA was not pleasant c (with) pt about going to BR...once in BR pt asked for assistance, pt has ataxia and must have help transferring. CNA stated "I'm not going to get anything done today, it's going to be a long day for me." Put her on a bed pan for 15 to 20 minutes...CNA just complained the whole time instead of asking for nurse's or other CNA's help c pt. It should be noted this pt has only used bed pan once the whole stay." The form read in part "person forwarded to for resolution - DON (Director of Nursing)." The form was signed and dated by the DON on 11/14/11 and the Administrator on 11/15/11.</p> <p>A Disciplinary Action Notice for NA#1, dated 11/8/11, read in part "11/4/11 failed to assist a resident to the bathroom as requested. Expressed concerns from residents stating employee has an unpleasant attitude and comments were felt to be inappropriate during interaction." The form was signed by NA#1, the DON, and administrator.</p> <p>In an interview on 1/26/12 at 11:59AM, Nurse #1 stated she went to the resident's room on 11/4/11 and saw that she was crying and upset. The resident needed to go to the bathroom while trays were being passed. The NA told the resident she didn't have time to take her to the bathroom and she could use the bed pan. The resident was placed on the bed pan and left for a long time. Nurse #1 stated the resident didn't normally use</p>	F 241	<p>and how it will be implemented and followed as well as which staff member has what responsibilities in meeting the requirements of the program. The CDM will train her staff on how the tray delivery system will change by 02-16-12. The new dining program will be implemented on 02-20-12. The 200 Unit is the short term rehabilitation unit and the new dining program will be implemented on this unit as soon as it is implemented on the 300 Unit.</p> <p><u>ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:</u></p> <p>The facility already has one system in place that functions to assist with maintaining the facility's standards of treating all residents with respect and dignity: the system consist of reporting any &amp; all resident and/or family concerns voiced by anyone to any staff member on a green "Resident &amp;/or Family Concern" form. These forms are immediately forwarded to the social worker who in turn brings all concerns to the facility morning meeting. Any immediate action is taken by Administration as may be appropriate. The concern is then forwarded to the respective department supervisor for investigation and for corrective action to take place. This occurred with the incident with Resident #128 and resulted in</p>	

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F 241	<p>Continued From page 3</p> <p>the bed pan. She had been put on the bedpan, maybe once, when she was first admitted. She stated the resident was quite capable of being transferred to the toilet. The NA had been "ugly" to the resident and made her feel like she had to stop what she was doing to take care of her. Nurse #1 stated "it's a dignity issue. I was upset that the NA would treat her like that." Nurse #1 stated she completed the Concern Form, forwarded it to the Social Worker, and asked for another NA to be assigned to the resident.</p> <p>In an interview on 1/26/12 at 2:06PM, the Director of Social Services stated once concern forms were completed, they were forwarded to her. She made copies and then directed the copies to the appropriate person to investigate. She was aware of the incident with resident #128. She stated the NA didn't assist the resident because trays were being passed. A Concern Form was completed and forwarded to the DON for resolution.</p> <p>In an interview on 1/26/12 at 4:48PM, the DON stated she was the assistant DON when the incident occurred on 11/4/11. A Resident Concern Form had been completed and forward to the acting DON at that time. She stated NAs were trained at orientation and had to complete a check list on the floor. She observed the NAs performing their tasks during training. NAs were expected to answer call bells and attend to residents' needs immediately unless they were actually feeding a resident. Her expectation was for the staff to always treat residents with the upmost respect and dignity. She stated "this is their home, that is what we expect of them." The DON considered NA #1's treatment of resident</p>	F 241	<p>the CNA's termination from the facility. In addition, beginning 02-15-12, the facility's Resident &amp; Family Advocate will visit all alert and oriented residents three times weekly and interview them concerning staff members treating them with respect &amp; dignity. If the facility's Resident &amp; Family Advocate receives any reports from the residents that they have been treated in any way with less than respect and dignity, this will be reported immediately on the Resident &amp;/or Family Concern Form and forwarded to the Administrator immediately. The Administrator will initiate an investigation immediately and will take the necessary appropriate action to ensure that resident's dignity and respect is maintained.</p> <p>The week day nurse manager and the week end nurse manager will be charged with the responsibility of overseeing the new dining program and ensuring that the program is effective in providing a rewarding dining experience for all residents. They will report to the Dining Committee any problems or needs for adjustment in the program.</p>		

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F 241	<p>Continued From page 4</p> <p>#128 "a dignity issue." She stated NA#1 was disciplined and terminated.</p> <p>In an interview on 1/26/12 at 5:12PM, the Administrator stated she started working at the facility on 11/7/11. The concern form for resident #128 was completed on 11/4/11 and forwarded to her later. She signed the concern form on 11/15/11. The Administrator stated the NAs were first trained during an orientation program at the facility and then on the floor. She stated there should always be someone available to answer call bells during meals. She expected the staff to treat residents with kindness, assist them to the best of their ability, and get additional help if needed. The administrator read the Family/Resident Concern form for resident #128 and stated "the NA should not have made these statements."</p> <p>In an interview on 1/26/12 at 5:59PM, the Administrator stated NA#1 had been terminated on 12/14/11.</p> <p>NA#1 was unavailable for interview.</p> <p>2. The facility policy, entitled Standards of Care for CNAs (certified nursing assistants), undated, read in part: "All residents are to be treated with respect, dignity, and kindness at all times...Residents are to receive care and services to maximize their well being in a competent and respectful manor...Employees are to conduct themselves in a professional manner at all times."</p>	F 241	<p><u>INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. :</u></p> <p>All Resident &amp;/or Family Concern Forms will be reviewed by the QA Committee at the monthly meetings for any violations of resident dignity and the interventions taken. The QA Committee will also review the reports from the Resident &amp; Family Advocate for any resident dignity violations and the resulting interventions. The QA Committee will monitor the two systems to ensure that corrective action is achieved and sustained.</p> <p>The Dining Committee will report to the QA Committee monthly on the implementation and maintenance of the new Resident Dining Program. The QA committee will monitor the performance of the new dining program to ensure that corrective solutions are achieved and sustained. The QA Committee will make recommendations to the Dining Committee for improvement to maintain effectiveness of the program to ensure a quality dining experience for all residents.</p>	

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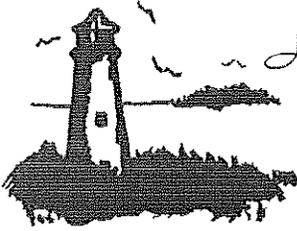
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F 241	<p>Continued From page 5</p> <p>Resident # 25 was admitted to the facility on 1/7/08 with an accumulative diagnoses including dementia. The Quarterly Minimum Data Set (MDS) assessment dated 11/27/11 indicated Resident # 25 had severe cognitive deficits and was dependent on staff for daily care, including feeding.</p> <p>On 1/23/12 at 4:45 pm, Resident # 25 was observed seated at a table in the dining room. Meal trays were delivered to the dining room at 5:00 PM. Meal trays were first delivered to residents who were able to feed themselves by four nursing assistants. By 5:40 PM, all residents who could feed themselves had been served, including a resident at Resident # 25's table. Two nursing assistants left the dining room to deliver meal trays to residents on the hall. Two nursing assistants remained in the dining room.</p> <p>On 1/23/12 at 5:43 PM, Nursing Assistant (NA) # 2 stated, "After trays are passed to the residents who can feed themselves, two nursing assistants go to the hall to pass out trays and feed. There are at least two aides left in the dining room to pass trays out to residents who need assistance, one at a time. We feed the resident, and then pass trays to another resident and feed them."</p> <p>On 1/23/12 at 5:58 PM, Resident # 25's meal tray was delivered and set up. Resident # 25 had been seated in the dining room for almost one hour with other residents who were eating before receiving his tray and feeding assistance.</p> <p>During an interview on 1/26/12 at 4:30 PM, the Administrator stated, "The nursing assistants are</p>	F 241			

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F 241	Continued From page 6 instructed to pass trays to everyone at a table so they can eat at the same time. Residents who can feed themselves are seated together and are served first. Residents who require feeding are seated together. I have not timed how long it takes for staff to feed those residents who need assistance."	F 241			



*Harborview Rehab & Health Care Center  
of Senior Care Properties, Inc.*

812 Shepard Street  
Morehead City, NC 28557  
252 726-6855  
Fax 252 808-2074

February 14, 2012

Dear Mr. Russell Carroll, RPH  
Facility Survey Consultant,

Thank you for your visit to our facility on January 26, 2012. Please accept this Plan of Correction for Harborview Rehab. & Health Care Center with date certain as of February 22, 2012.

If I can be of any further assistance, please feel free to call me anytime.

Sincerely,

Debra Hamilton, NHA  
Administrator

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<p>K 000 INITIAL COMMENTS</p> <p>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction, two stories, with a complete automatic sprinkler system.</p> <p>The deficiencies determined during the survey are as follows:</p> <p>K 012 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/2/12 the following building construction item was non-compliant, specific findings include, foam used in the corridor wall of the 1st floor mechanical room.</p> <p>K 051 NFPA 101 LIFE SAFETY CODE STANDARD SS=D A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the</p>	<p>K 000</p> <p>Foam was removed and penetrations grouted &amp;/or fire caulked in the first floor Mechanical room.</p> <p>All fire/smoke wall penetrations will be inspected for foam and if any is present it will be removed and replaced with grout and/or fire caulk as documented in Maintenance log.</p> <p>Foam will not be used for sealing penetrations in fire walls. There will be no penetration of fire walls without the authorization of the Maintenance Supervisor. Maintenance personnel was in-serviced on the proper sealing of fire walls and foam will not be used. Maintenance logs will be brought to QA for QA audit/results. Batteries were replaced.</p> <p>K 051 Fire alarm system backup system will be checked weekly for 4 weeks. The fire alarm batteries will be checked monthly for next 3 months during fire drill. Fire alarm panel will be inspected &amp; serviced twice annually by an independent party. All results will be taken to QA.</p>
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4-6-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nobra Hamilton TITLE: Administrator (X6) DATE: 3-16-12

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DLW

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K 051 Continued From page 1  
path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6

K 051

This STANDARD is not met as evidenced by:  
42 CFR 483.70(a)  
By observation on 3/2/12 the following fire alarm system was non-compliant, specific findings include, the pull station at the 2nd floor nurses station did not activate the fire alarm while the fire alarm system was on back up battery.

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NAME OF PROVIDER OR SUPPLIER  HARBORVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 812 SHEPARD ST MOREHEAD CITY, NC 28557
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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)	(X6) COMPLETION DATE
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K 000	INITIAL COMMENTS	K 000		
	<p>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction, two stories, with a complete automatic sprinkler system.</p> <p>There were no Life Safety Code Deficlencies noted at time of survey.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.