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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	C 08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LEAF HEALTH CARE	2640 DAVIE AVENUE STATESVILLE, NC 28625

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to follow physician's orders for one (1) of eleven (11) sampled residents reviewed for unnecessary medications and one (1) of one (1) sampled residents receiving dialysis (Resident #54). The findings are: Resident #54 was admitted to the facility on 4/20/11 with diagnoses that included hypertension, end stage renal disease, diabetes, anemia, and neuropathy among others. The most recent Minimum Data Set (MDS) dated 7/23/11 specified the resident had mild cognitive impairment and was receiving dialysis. Resident #54's dialysis care plan dated 5/11/11 and updated 6/22/11 specified the resident attended dialysis three times weekly. The care plan specified interventions to ensure the resident did not experience complications included: - Vital signs checked every shift for 24 hours post dialysis or per physician's orders Review of Resident #54's medical record revealed an original physician's order dated 5/27/11 that specified to check vital signs every shift for 24 hours post dialysis. Further review of the medical record revealed the resident was	F 281	F 281 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #54 by obtaining vital signs as ordered by the physician and as ordered after hemodialysis treatment. Resident #54 is not at the facility at this time but is expected to return. 2. Residents who require monitoring of vitals signs due to medication administration or hemodialysis treatment have the potential to be affected by the same alleged deficient practice and have been identified by the Director of Nursing (DON) via medical record audit. Newly admitted residents who require vital signs monitoring and/or hemodialysis treatment will be identified via physician's orders. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The DON, RCMD(Resident Care Management Director), or MDS Coordinator will conduct inservice education for licensed nurses regarding professional "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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	9/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glen K. Simon — TITLE: Administrator — (X6) DATE: 8/29/11

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.

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F 281	Continued From page 1 prescribed medication for the treatment of hypertension and had recently experienced fluctuations in his blood pressure that required medication adjustments. Resident #54's Medication Administration Record (MAR) for the month of 7/11 revealed eight (8) incidents of no documented vital signs following a dialysis session. The resident's nurses' notes revealed no additional vital signs during 7/11. On 8/11/11 at 7:45 a.m. the licensed nurse (LN) #1 assigned to care for Resident #54 was interviewed and reported that he was assigned to check Resident #54's vital signs during the 11 p.m. to 7 a.m. shift. LN #1 indicated the resident was typically still awake at 11 p.m. and agreeable to have his vital signs taken at that time. He added that any episodes of vital signs not documented as being done on the MAR was an oversight. On 8/11/11 at 11:30 a.m. the MDS Coordinator was interviewed. She reviewed Resident #54's medical record and verified there were eight (8) episodes of vital signs not documented as having been completed. She reported that the licensed nurses should document the vital signs on the MAR and offered no explanation why the resident had eight (8) out of thirty nine (39) vital signs left blank on the MAR. On 8/11/11 at 12:00 p.m. the Director of Nursing (DON) was interviewed and reported she expected licensed nurses to follow physician's orders as written and offered no explanation why the resident's vitals signs were not obtained for 24 hours post dialysis as ordered.	F 281	standards of practice, specifically, following physicians' orders in regards to obtaining vitals signs to monitor hemodialysis residents post-treatment and for those residents who require monitoring of vital signs due to medications ordered. The DON, RCMD, or MDS Coordinator will monitor documentation of vital signs as ordered by the physician post-dialysis for those residents who receive hemodialysis services and for those residents who require monitoring of vital signs due to medication orders daily for 14 days, then weekly for 4 weeks, then monthly for 3 months to validate documentation of vitals signs as ordered. The Medical Records Coordinator, DON or RCMD will review Medication Administration Records for hemodialysis residents and residents who require vitals signs monitoring due to medications monthly thereafter to ensure continued compliance. 4. The DON, RCMD, or MDS Coordinator will review data obtained during vital signs audits, "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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	9/8/11

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to manage and implement planned measures for adequate bowel elimination patterns for one (1) of ten (10) sampled residents (Resident #s 34). The findings are: Resident #34 admitted to the facility on 2/11/09 with diagnoses that included constipation. The most recent Minimum Data Set (MDS) dated 5/19/11 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making. The MDS also specified the resident was incontinent of bowel and required extensive assistance with toileting. Review of Resident #34's medical record revealed a physician's order dated 2/13/09 that specified the resident was to receive 30 cc (cubic centimeters) of Milk of Magnesia (laxative) by mouth daily as needed for constipation. Resident #34's bowel elimination records were	F 309	analyze the data and report patterns/trends to the QA&A committee monthly for 6 months. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. F 309 1. Corrective action has been accomplished for the alleged deficient practice for Resident #34 by evaluating the resident for the need for a bowel protocol. The physician was contacted for orders in the event that the resident does not have a documented bowel movement after three days. Resident #34 is monitored daily by nursing staff for bowel movements and nursing staff document results accordingly. 2. Current facility residents have the potential to be affected by the same alleged deficient practice; therefore, the DON, RCMD, or MDS Coordinator has reviewed records obtained from the Care "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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	9/8/11

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F 309	Continued From page 3 reviewed and revealed the following: a. Starting on 6/16/11 and continuing for thirteen (13) shifts no bowel movements were documented. b. Starting on 7/6/11 and continuing for seventeen (17) shifts no bowel movements were documented. A review of nursing notes for Resident #34 for the periods of 6/16/11 through 6/20/11 and 7/6/11 through 7/12/11 revealed no documentation of assessment for constipation or implementation of the resident's laxative ordered for constipation. Review of the Medication Administration Record (MAR) and physician orders revealed no additional orders and/or interventions to address the two (2) episodes of constipation. On 8/11/11 at 11:15 a.m. the Director of Nursing (DON) was interviewed and reported all residents were monitored to ensure they had an adequate bowel elimination pattern. Her expectation was that if a resident had not experienced a bowel movement in nine (9) shifts, the licensed nurse was to administer medications or call the physician. The DON added the MDS Coordinator ran a report daily Monday through Friday that specified if a resident had not experienced a bowel movement in nine (9) shifts. The DON reviewed Resident #34's bowel elimination records and offered no explanation why no interventions were implemented for the two (2) documented episodes of constipation. On 8/11/11 at 11:40 a.m. the MDS Coordinator was interviewed and reported she ran a report	F 309	Tracker documentation system to determine if any other resident has not had a bowel movement in three days or more. If identified, the attending physician has been notified to request orders for intervention. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the DON, RCMD, or MDS Coordinator will conduct inservice education for nursing staff regarding the provision of quality of care, specifically, the procedure for obtaining a list of residents from the Care Tracker system regarding bowel movements; how to determine whether there has been a period of 3 days or more between bowel movements and notification of the physician for additional orders for treatment. The DON, RCMD, or MDS Coordinator will receive a copy of the report daily and follow up with charge nurses to assure procedure is followed accordingly to ensure continued compliance. "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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	9/8/11

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F 309	Continued From page 4 daily Monday through Friday that indicated if a resident had not experienced a bowel movement in the last nine (9) shifts. She added that she distributed the reports to the assigned licensed nurses to assume responsibility. The MDS Coordinator reported that the hall nurses were responsible for running the report on the weekends. She added she did not follow-up or monitor to see if the assigned licensed nurses addressed the episodes of constipation. On 8/11/11 at 11:50 a.m. licensed nurse (LN) #2 was interviewed and reported she was given a report when a resident had not experienced a bowel movement in nine (9) shifts. She added she assessed the resident for constipation, checked for bowel sounds and administered medications if ordered or she called the physician for further orders. She reviewed Resident #34's bowel elimination records and was unaware the resident had two episodes of no bowel movement in greater than nine (9) shifts. She reviewed the resident's physician orders and confirmed the resident had a laxative ordered as needed for constipation.	F 309	4. The DON, RCMD or MDS Coordinator will review data obtained during daily report audits, analyze the data and report patterns/trends to the QA&A committee monthly for 6 months. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	9/8/11