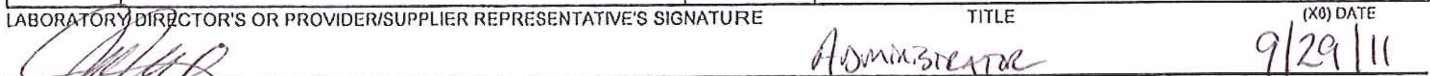
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345393	A. BUILDING ______ B. WING ______	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PISGAH MANOR HEALTH CARE CENTER	95 HOLCOMBE COVE ROAD CANDLER, NC 28715

(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 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		
	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.		F.314 1. Instruction and teaching was given to the RNs/LPNs and CNAs on 09/16/11 as to the importance of turning/repositioning the affected resident. A turn schedule was instituted to ensure the affected resident is turned from side to side at the proper times on 9/16/11.	9/16/11
	This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews facility staff failed to turn and reposition a resident with a stage 3 pressure ulcer on her sacrum in one (1) of three (3) sampled residents. Resident # (101).		2. A turn schedule will be implemented for all residents with pressure ulcers Stage 2 or greaterto ensure the residents are turned at the proper times. A memo was posted to reinforce the importance of turning and repositioning on 09/27/11.	9/22/11
	The findings are: A review of a facility policy and procedure titled "Simple Wound and Skin Ulcer Care" dated 06/22/2011 stated in part to "schedule regular and frequent turning and repositioning for bed and chair-bound residents. Turn at least every two (2) hours on a pressure reducing mattress as well as a non-pressure reducing mattress." Resident #101 was admitted to the facility on 06/18/2011 with diagnoses including urinary retention, multiple sclerosis and depressive disorder. The initial admission Minimum Data Set (MDS) dated 06/28/2011 indicated no impairment in		3. Nursing administration to provide education/instruction to the nursing staff regarding the implementation of the turning schedule to ensure the residents are turned at the proper times. Also, assignments were made for CNAs to view the online program on turning and repositioning in HCA (web-based in service program).	9/30/11



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/29/11

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 314	Continued From page 1 short and long term memory and no impairment in cognition for daily decision making. The resident required extensive assistance with two plus person assistance for turning and positioning in bed. A review of a plan of care dated 07/07/2011 revealed a problem for potential skin breakdown with interventions listed in part for staff to assist with turning and positioning every two (2) hours and as needed. A review of the "Completed Care Tasks" dated 09/14/2011 revealed Resident #101's name and "Turned/or repositioned every two (2) hours this shift" documented three (3) times with the time of 02:59 PM for each entry. During an observation on 09/14/2011 at 9:41 AM LN #10 completed the dressing change to Resident # 101's sacral wound and assisted NA #12 to turn Resident #101 to her right (R) side, raised the left (L) side rail and placed a pillow behind her back. During continuous observations on 09/14/2011 from 9:41 AM until 12:03 PM Resident #101 was lying on her (R) side in bed with the head of the bed lowered. No staff members were observed going in or out of the resident's room. During an observation on 09/14/2011 at 12:03 PM NA #12 entered the Resident #101's room to give her a bath. Resident #101 was still lying on her (R) side and NA #12 removed the pillow from behind her back. During an interview on 09/14/2011 at 8:48 AM	F 314	4. DON, ADON, and/or SDC will check all residents with pressure ulcers for proper/timely turning and repositioning. These checks will be done 2x week x 3 weeks, weekly x 3 wks, then monthly x 2 months. The audits of the turning schedules and positioning of residents will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	9/30/11

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F 314	Continued From page 2 with LN #10, she stated Resident #101's wound was clean when she last saw it but it had tunneling and she thought the tunneling was worse. During an interview on 09/14/2011 at 12:48 PM with NA #12 she verified the pillow behind Resident #101's back was in the same position since they did her wound care earlier this morning. She stated she was aware they were supposed to turn Resident #101 every two (2) hours. She further stated they usually turned residents when they first came on their shift but they don't use any kind of schedule to indicate when to turn the residents. During an interview on 09/15/2011 at 8:49 AM with LN #11 she verified Resident #101 did not have any pressure ulcers when she was admitted to the facility and the resident started to decline after she was admitted. LN #11 stated Resident #101 should be turned every two hours or more frequently, she could sit up for meals only and she had an air mattress on her bed. She explained the Nursing Assistants document their daily tasks on a document titled "Completed Care Tasks" in the facility computer system and verified there were three entries dated 09/14/2011 at 2:59 PM. She stated that according to the documentation she could not verify when Resident #101 had been turned. During an interview on 09/15/2011 at 9:39 AM with the Director of Nurses (DON) she stated it was her expectation that for any resident who had a pressure ulcer it was imperative they be turned and repositioned to keep them off the area. She verified the facility did not use any type of turning	F 314		

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F 314	Continued From page 3 schedule but it was her expectation that Nursing Assistants turn and reposition residents with pressure ulcers every two hours or more often. During an interview with a Hospice Nurse on 09/16/2011 at 9:19 AM she stated it was her expectation that Resident #101 should be turned and repositioned at least every two (2) hours. She further stated Resident #101 could not sit because of the pressure ulcer on her sacrum and laying in bed and not moving put her at risk for further skin breakdown. She stated she expected staff should communicate with each other regarding when Resident #101 needed to be turned.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility staff failed to clean around an indwelling catheter during incontinence care for one (1) of four (4) sampled residents. Resident # (101).	F 315	**F.315** 1. Instruction and teaching was given on proper catheter care to the CNA for the affected resident. 2. Instruction and teaching was given on proper perineal care and catheter care to the CNAs for all residents with catheters.	9/15/11 9/23/11

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F 315	Continued From page 4 The findings are: A review of a facility policy and procedure titled "Catheter Care" dated 05/17/2006 stated in part that catheter care is to be provided every shift by the assigned Nursing Assistant. It further stated the procedure for females was to "gently wash genital area round catheter from front to back with warm soapy water." Resident #101 was admitted to the facility on 06/18/2011 with diagnoses including urinary retention, multiple sclerosis, and depressive disorder. The initial admission Minimum Data Set (MDS) dated 06/28/2011 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The resident was totally dependent on staff for bathing and required extensive assistance with toileting. A review of the Care Area Assessment dated 07/01/2011 indicated Resident #101 triggered for urinary incontinence and indwelling catheter. A review of an undated document titled "Care Guide" as an attachment to the plan of care stated "catheter care." A review of a physician's encounter note dated 08/22/2011 stated Resident #101 had a urinary tract infection at the beginning of August 2011 due to urinary retention. During an observation on 09/14/2011 at 12:03 PM Nursing Assistant (NA) #12 entered Resident #101's room to give her a bath. NA #12 bathed	F 315	3. Meetings were held with RNs/LPNs and CNA's to discuss the importance of proper perineal care and catheter care. A memo was posted for RNs/LPNs and CNA's to reinforce the importance on 09/27/11. Assignments were made for CNAs to view the online program on proper perineal and catheter care in HCA (web-based in service program). 4. DON, ADON, and/or SDC will check all residents with catheters to ensure proper perineal care and catheter care is being administered. These checks will be done 2 x wk x 3 wks, weekly x 3 wks, then monthly x 2 months. The audits of perineal care and catheter care will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	9/30/11 9/30/11

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F 315	Continued From page 5 Resident #101 then removed the resident's brief. Resident #101 had an indwelling catheter in place and NA #12 wiped the resident's skin between her legs back and forth with a wet, soapy washcloth but did not clean around the indwelling catheter. During an interview on 09/14/2011 at 12:48 PM with NA #12 she verified she did not clean around the catheter when she bathed Resident #101. She stated she knew that she should have cleaned around the indwelling catheter but she did not know why she didn't clean around it. During an interview on 09/15/2011 at 8:49 AM with Licensed Nurse (LN) #11 she verified Resident #101 had an indwelling catheter because of urinary retention and thought the resident had a urinary tract infection in the past. She explained that Nursing Assistants (NA's) received orientation when they were hired regarding expected techniques for incontinence care and cleaning around an indwelling catheter. She stated it was her expectation that NA's should always clean around an indwelling catheter whenever they bathed residents or provided incontinence care. She verified that catheter care included cleaning around the catheter and the catheter itself during bathing or when incontinence care was provided. During an interview on 09/15/2011 at 9:39 AM with the Director of Nurses (DON) she stated it was her expectation that nursing assistants should always clean around an indwelling catheter when they bathed a resident or provided incontinence care.	F 315		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 6 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 observation, staff interviews, resident interviews, and record review, the facility failed to provide ambulation assistance for one (1)out of five (5) sampled residents at risk for falls (Resident #66). The findings are: Resident #66 was admitted to the facility on 10/05/2010 with diagnoses which included Generalized Anxiety, Coronary Artery Disease and Benign Positional Vertigo. The most recent quarterly Minimum Data set dated 070/8/2011 listed Resident #66 as cognitively intact with the requirement of extensive assistance of one person for transfers and toilet use. There was no fall history. Review of Resident #66's care plan updated 07/14/2011 related to fall risk included the interventions of hospice notification of pain needs, psychiatric consult as needed for anxiety/depression, eye glasses, verbal reminders not to ambulate or transfer without assistance, proper fitting non-skid shoes and	F 323	**F323** ***Finding #1:*** 1. Instruction was given CNA on properly assisting affected resident to the bathroom. When affected resident request more assistance with ambulation the staff member is to ensure safety by seeking assistance from additional staff members or use of a mechanical device i.e., wheelchairs, lifts and/or gait belt. 2. Instruction was given to RNs/LPNs and CNAs that all residents requesting assistance with ambulation receive assistance as needed and request additional staff to assist and/or use mechanical devices. 3. Meetings were held with RNs/LPNs and CNAs to discuss the procedure and importance of the safety of the resident during ambulation. A memo was posted on 09/27/11for RNs/LPNs and CNAs to reinforce the importance.	9/15/11 9/30/11 9/30/11

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F 323	Continued From page 7 placement of frequently used items within reach. The care plan also listed impaired mobility as a problem with interventions which included assist with positioning, transfers, ambulation as necessary or as requested. Review of an initial fall report dated 09/12/2011 revealed Resident #66 fell in the room during ambulation with a Nursing Assistant (NA). Review of the incident follow-up dated 09/13/2011 revealed the NA lowered Resident #66 to the floor during ambulation with a rolling walker after toileting. The documentation noted Resident #66's anxiety at times with care. The follow-up updated 09/14/2011 documented a discussion with Resident #66 of wheelchair use to prevent tiredness Review of a nursing note dated 09/14/2011 revealed left shoulder, right hand and wrist x-rays were negative for fracture post fall. Interview with Resident #66 on 09/13/2011 at 3:30 PM revealed after the fall she felt pain so x-rays were taken. Resident #66 explained she fell because the nursing assistant did not listen to her. Resident #66 explained she directed NA #10 to get help to help her walk to the bathroom. Resident #66 reported her weak legs cause her to need more help at times and she did not know NA #10's capabilities since she was new to her. Interview with NA #1 on 09/13/11 at 3:50 PM revealed she was in the process of orienting NA #10 to the care of residents in her assigned group. NA #1 explained Resident #66's call light summoned NA #10 while she was with another	F 323	4. DON, ADON, and/or SDC will check residents requiring assistance with transfer/ambulation to ensure residents are receiving the proper number of staff and/or use of mechanical devices-lifts, gait belt and wheelchairs. These checks will be conducted 2 x week x 3 weeks, weekly x 3 weeks, then monthly x 2 months. The audits of residents requiring assistance with transfers and ambulation will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	9/30/11

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F 323	Continued From page 8 resident. NA #1 reported she directed NA #10 to help Resident #66. NA #1 explained NA #10 assisted her with Resident #66 the past four days and knew Resident #66's needs. NA #1 reported Resident #66 required one person's assistance and a walker for ambulation unless her legs were weak. An interview was conducted with NA #10 on 09/13/2011 at 4:05 PM, NA #10 stated that on 09/12/11 Resident #66 informed her that her legs might be too weak to go to the bathroom with just her assistance and the walker. NA #10 reported she reassured Resident #66 and helped the resident ambulate with the walker to the toilet as she did before under the guidance of NA #1. When Resident #66 was ready to be ambulated from the bathroom, she held onto Resident #66's arm. When the resident told her she was holding the arm too tight, NA #10 explained she loosened her grip and the resident began to fall. NA #10 explained she lowered Resident #66 to the floor and summoned help. Interview with Licensed Nurse #9 on 9/14/2011 at 6:06 AM revealed Resident #66 required one or two persons for transfer and ambulation assistance. LN #9 reported Resident #66 knew the level of assistance she required and told staff how many people were needed to help her. Interview with NA #11 on 09/14/2011 at 6:35 AM revealed Resident #66 required two persons for transfer to the bedside commode during the night for the past two months. NA #11 explained Resident #66 told her how many people she required for assistance.	F 323		

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F 323	Continued From page 9 Interview with NA #7 on 09/14/2011 at 8:25 AM revealed Resident #66 required one or two persons for transfers and ambulation assistance. NA #7 explained Resident #66 informed staff of the condition of her legs and the number required for transfer and ambulation. Interview with LN #8 on 09/14/2011 at 8:41 AM revealed Resident #66 usually required one person for assistance in transfers and ambulation. LN #8 explained the resident would tell staff what she needed. Interview with LN #4 on 09/14/2011 at 3:32 PM revealed Resident #66 usually required one person with transfers and ambulation. LN #4 explained if Resident #66 requested two persons to assist, staff should provide two persons. Interview with Resident #66's hospice aide on 09/15/2011 at 8:20 AM revealed Resident #66 required one or two persons for transfers and ambulation. The hospice aide explained Resident #66 directed the number of persons required. Interview with NA #6, a restorative aide, on 09/15/11 at 8:53 AM revealed Resident #66 usually required one person with ambulation and transfers. NA #6 explained Resident #66 informed staff if she needed two persons. Interview with the Director of Nursing on 09/15/11 at 10:40 AM revealed if a resident requested a staff member to obtain another staff member's assistance, then two persons should be provided.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 10 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility had a medication error rate of 5.17% with three (3) medication errors out of fifty-eight (58) opportunities. Two (2) of eleven (11) residents observed during medication pass had errors in administration. (Resident # 102 and # 10). 1. Resident # 102 was admitted with diagnoses which included osteoporosis and hypertension. A review of the September 2011 monthly recapitulation of physician's orders included an order which read: "Calcium Citrate 200mg give one caplet every evening by mouth." Licensed Nurse # 2 (LN # 2) was observed on 09/13/2011 at 4:06 PM administering medication to Resident # 102. LN # 2 removed a bottle labeled Calcium Citrate with Vitamin D from the stock medication on the medication cart. The bottle label indicated each capsule contained Calcium Citrate 250mg and Vitamin D 125mg. LN # 2 stated: "This has 250mg of Calcium and the Medication Administration Record (MAR) says Calcium Citrate 200mg but I guess it will be alright to give it." An interview with the Director of Nursing (DON) on 09/14/2011 at 4:15 PM revealed her expectation is that medications be administered	F 332	**332** 1. Instruction on proper/accurate administration of medication was discussed with nurses administering po meds and inhalers to affected residents. 2. Instruction on proper administration of medication was given to RNs/LPNs for all residents receiving medication. 3. Meetings were held with RNs/LPNs to discuss the importance of accurate medication administration. A memo was posted on 09/27/11 regarding giving the instructions on proper administration of meds. 4. DON, ADON, and/or SDC will do med pass checks with nurses administering po meds and inhalers to ensure the proper dose and guidelines are followed. Checks will be done 2 x wk x 3 wks, weekly x 3 wks, then monthly x 2 months. 9/26/11 The audits of med passes will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	9/14/11 9/30/11 9/30/11 9/30/11

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F 332	Continued From page 11 as ordered. The DON stated all nurses receive continuing education on medication administration through internet-based training, nurse's meetings and inservices provided by the pharmacy consultant. 2. Resident # 10 was admitted with diagnoses which included hypertension, diabetes mellitus and coronary artery disease. A review of the September 2011 monthly recapitulation of physician's orders included the following: "Spiriva 18mcg(micrograms) handihaler - give every day and Ventolin 90mcg inhaler give 2 (two) puffs twice daily." LN # 3 was observed on 09/14/2011 at 9:32 AM administering medication to Resident # 10. LN # 3 administered all oral medications to Resident # 10 with a glass of water. a. LN # 3 then gave Resident # 10 the Spiriva 18mcg handihaler (an anticholinergic agent) to inhale. Resident # 10 inhaled the puff and handed the device back to the nurse. LN # 3 waited 30 (thirty) seconds after Resident # 10 inhaled the Spiriva. b. LN # 3 then gave Resident # 10 the Ventolin 90mcg inhaler (a bronchodilator) to inhale Resident # 10 inhaled one puff of medication and LN # 3 told her to wait before inhaling the next puff of medication. After 15 (fifteen) seconds LN # 3 told Resident # 10 to inhale another puff of medication. Resident # 10 inhaled a second puff of the medication and handed the device back to the nurse. Manufacturer ' s recommendations for Ventolin	F 332		

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	345393	A. BUILDING ______ B. WING ______	09/16/2011

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F 332	Continued From page 12 (albuterol) state: " Wait at least one full minute between inhalations. If more than one inhalation medication is used, use albuterol first and wait five (5) minutes between medications. " An interview on 09/14/2011 at 3:05 PM with LN # 3 about the length of time to wait between different inhalers, she stated: "2 - 3 minutes." When asked about the length of time to wait between puffs of the same inhaler, she responded: "At least a minute." An interview on 09/14/2011 at 4:15 PM with the director of nursing (DON) about her expectation regarding administration of inhaler medication revealed the nurse should wait 5 (five) minutes between two different inhalers and should wait 1 (one) minute between puffs of the same inhaler. She stated each medication cart has a reference sheet that specifies the guidelines for administration of inhaler medications. A review of reference instructions on the medication cart read: "Pause one (1) to two (2) minutes between inhalations of the same medication. It is suggested to wait approximately five minutes between inhalations of different medications. Administer bronchodilators first. Administer anticholinergic agents second." An interview on 09/15/2011 at 9:11 AM with the DON revealed all nurses are provided continuing education on medication administration through internet-based training, nurse's meetings and inservices provided by consultant pharmacist	F 332		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 13 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 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility record review the facility failed to ensure staff dated three opened food items placed back in the walk in refrigerator for storage. The findings are: A copy of the facility's policy and procedure for storing food items was requested and furnished. The facility provided a copy of their policy and procedure and a copy of the facility's additional food storage/labeling requirements. A review of the facility's policy and procedure and additional food storage/labeling requirements was conducted on 09/16/2011 at 7:45 AM. The facility's food storage policy and procedure documented in paragraph (item) #2: "When ever the cooks or aids are storing any foods, make sure the food is in appropriately sealed containers with the name of food and date." The facility's additional food storage/labeling of food items requirements were also reviewed.	F 371	**F371** 1. All undated/unlabeled items were immediately discarded on 09/12/11. 2. A further review was completed by the CDM and found all other opened food items were properly labeled and dated. An inservice for all dietary staff was completed on 09/26/11 to educate them on our policy and the importance that all food is in appropriate sealed containers with the name of the food and date. 3. The CDM will conduct inservices with all new associates and annually thereafter to all associates on our policies regarding storage of opened food. 4. The CDM or Asst. Dietary Mgr. will perform random audits to ensure all opened food is properly stored. Audits will be performed 2 x week for 3 weeks, then weekly x 3 weeks, then monthly x 2 months. The audits of proper food storage will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	9/12/11 9/26/11 9/26/11 9/30/11

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F 371	Continued From page 14 The additional requirements documented under - Labeling of Food Items (paragraph #1): "All leftovers shall be labeled and dated by the cook from each respective shift. Once dated and labeled all food shall be placed in the refrigerator." On 09/12/2011 at 8:27 AM a tour of the facility's kitchen was made with the facility's assistant dietary manager. During the tour the following three previously opened and undated items were observed in the facility's walk in refrigerator: 1) A 1/2 full bag of grated Mozzarella cheese. The grated Mozzarella cheese was observed to have been opened in it's original bag and used. During the observation the cheese bag was identified as not having an opened date on the bag or clear plastic wrap used to re-seal the bag to identify when the bag was initially opened. 2) A 1/2 full bag of grated Swiss cheese. The grated Swiss cheese was observed to have been opened in it's original bag and used. During the observation the cheese bag was identified as not having an opened date on the bag or clear plastic wrap used to re-seal the bag to identify when the bag was initially opened. 3) A 1/2 full container of Ricotta cheese. The Ricotta cheese original container was observed to have been opened and used. During the observation the original cheese container was identified as not having a date on the container to identify when the container was initially opened. On 09/12/2011 at 8:35 AM an interview was conducted with the assistant dietary manager.	F 371		

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F 371	Continued From page 15 The assistant dietary manager acknowledged and confirmed there were no dates documented on the identified food items to show when each of the items was initially opened for use prior to placing the items back into the walk in refrigerator. The assistant dietary manager stated the facility had a policy and procedure which required all kitchen staff to document opened food items with the date prior to placing the items back in the refrigerator or freezer.	F 371		