

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

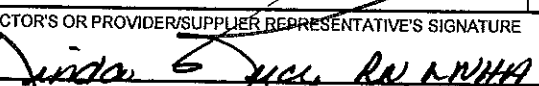
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PRINTED: 09/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE OF ELKIN	STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621
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F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record reviews, the facility failed to identify medical symptoms for 3 of 4 sampled residents with restraints and failed to implement systematic approaches to reduce restraints(Residents #134, #100 and #84).</p> <p>The findings included: Facility policy titled " Physical Restraint " dated 9/10, read in part; all residents determined to require a physical restraint will have a physician's order for the device. The following information will be included in the physician's order; medical diagnosis for restraint, type of restraint, why the restraint is used and the physical restraint is to be monitored according to the individuals care plan. In addition, restraint committee will meet at least monthly or more frequently as determined by resident or healthcare center need. The following would be reviewed; physical restraint assessments, determine that all possible physical restraint alternatives have been attempted for each resident assessed prior to utilization of a physical restraint, evaluate each resident for least restrictive device or physical restraint in place, evaluate the physician's order for appropriateness, review each care plan and ADL</p>	F 221	<p>Disclaimer Clause: Preparation and/or execution of</p> <p>This POC does not constitute admission or agreement by</p> <p>The provider of the truth of the facts alleged or</p> <p>Conclusion set forth in the statement of deficiencies the POC is</p> <p>Prepared on/or executed solely because it is required by Federal and State Law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE RN, MPH	(X6) DATE 10-26-11
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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 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 221	Continued From page 1 record to determine whether they are reflective of the resident's assessed needs and interventions regarding physical restraints, determine that the resident's family/responsible party has been notified. When the resident's physical restraint has been determined to be used as an intervention for emergent and/or therapeutic care and treatment, the physical restraint will only be used for certain time periods and under specific conditions, referring resident's for behavioral, therapy, activity, social or other programs as indicated in effort to reduce physical restraints, evaluating the physical environment for potential adaptations that would eliminate or decrease physical restraint usage. Reporting and coding on the resident's MDS, section P40100 should only be coded for those devices categorized as a physical restraint and not an assistive device that enables the resident to be more independent. 1. Resident #134 was admitted to the facility on 11/5/09. Resident #134 cumulative diagnoses included dementia, cerebral vascular accident, congestive heart failure, general muscle weakness and degenerative joint disease. The quarterly Minimum Data Set (MDS) dated 8/17/11, indicated that Resident #134 had severe short and long term memory and decision making problems. The MDS also indicated that Resident #134 was hard of hearing and required the use of an assistive device and still had difficulty understanding verbal content and reminders to help make sense of the things even when voice tone was not at an elevated volume in one ear. Section P of the MDS was not coded for the use of restraint. Resident #134 was involved in a toileting program and had made some progress, but needed assistance with transfers and	F 221	1. Corrective action has been accomplished for the alleged deficient practice for Residents # 134, 100, and 84 through reevaluation and reassessment of the necessity for physical devices. Based on the reevaluations, the use of physical devices was determined based on individual resident needs and such determinations recorded appropriately in the clinical record. 2. Residents with the potential to be affected by the alleged deficient practice were identified through 100% audit of residents with an assessed need for safety devices. All residents with safety devices in place were reassessed with the least restrictive device implemented.	9-22-11 9-22-11

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F 221	<p>Continued From page 2 ambulation.</p> <p>The physician's order dated 8/7/11, documented lap buddy for safety and positioning. There was no medical symptom indicated. Resident #134 has been in restorative ambulation 15 minutes per day since January 2010. Review of the physician's notes dated 5/23/11 to 8/9/11, revealed that Resident #134 's was very hard of hearing, general health remains stable and no notation of concerns with falls, transfers or mobility. The notes indicated that Resident#134 spends most of her time sitting with her legs down and continues to be monitored for edema and overall health was stable.</p> <p>Review of activities of daily living Resident Assessment Protocol (RAP) summary dated 9/22/10, revealed that Resident #134 depended upon staff for locomotion once in the wheelchair off the unit. Resident #134 ambulated with limited assist from the staff and restorative aides with use of rolling walker. Resident #134 stated "I just can't roll that far yet." Resident was ambulating with staff with use of a rolling walker. She had decreased standing and sitting balance requiring assistance from staff.</p> <p>The physical restraint evaluation dated 8/7/11, revealed the restraint device was a lap buddy and the medical symptom which led to the consideration of the physical device was N/A(not applicable). Resident #134 required extensive assistance with bed mobility and transfers, occasional incontinent of bowel and bladder. Follow-up assessment review dated 8/15/11, revealed the medical symptom was legs weak and requires walker for support and ambulatory</p>	F 221	<p>3. Measures put in place to ensure the alleged deficient practice does not recur include: The Clinical Care Coordinator will inservice all nursing staff on use of safety devices. The Director of Health Services and/or the Assistant Director of Health Services will monitor all residents with devices in place 5 days a week x 4 weeks, monthly x 3, then quarterly ongoing. Compliance rounds will be documented to reflect any inconsistencies or problems with device use.</p> <p>4. The results of monitoring will be reviewed weekly in morning meeting and monthly during PI meetings. Adjustments will be implemented as necessary based on the results of monitoring to ensure compliance.</p>	10-19-11	

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F 221	<p>Continued From page 3</p> <p>with restorative. Additional follow-up assessment dated 9/9/11, revealed that Resident continue to use lap buddy and the medical symptom included, muscle weakness and unable to stand without 1 to 2 assist, improve posture and balance. There was no current rehabilitation therapy assessment available. Review of the nurse's notes and incident reports dated 6/18/11 and 8/16/11. On 6/18/11, revealed that Resident#134 was observed sitting on the floor in the bedroom in front of wheelchair and Resident #134 stated that "I was trying to get up. " This was the only incident where the resident was observed on the floor in the bedroom. The report did not indicate whether the resident had fell from the wheelchair or bed. There were no further incidents of falls until 8/16/11. The intervention included "making sure the tabs monitor was attached to resident when up." The lap buddy had been implemented on 8/7/11, for positioning, Resident had not had any falls since 6/18/11. On 8/16/11 staff was present when the resident tried to stand up and fell to her knees after removing lap buddy. The intervention included " add lap buddy." There were no injuries in each of the incidents, nor was there any other alternative assessment or device attempted per notes or reports.</p> <p>Review of the care plan dated 8/22/11, identified the problem as: 1. potential for falls r/t falls on 6/18/11 and 8/16/11 when she took off her lap buddy and stood up without assistance gait unsteady, balance is impaired. The goal was Resident #134 will have no falls r/t(related to) injuries x 90 days. The approaches included remind resident to call for assist with transfers and/or ambulation, keep bed in low position at all</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>times, call light within reach, maintain safety with transfers, remind resident to call for assist with transfers and to use her walker with ambulation, lap buddy. 2. Decline in ability to ambulate independently. The goal included Resident #134 will ambulate 50-125 ft daily x 90 days. The approach included the rolling walker with supervision and verbal cues to stand up tall stay close to rolling walker, monitor and document program. There was no indication on the care plan of the frequency and duration of use for the lap buddy.</p> <p>During an observation 9/6/11 at 2:30PM, Resident #134 was seated in hall way in front of room with lap buddy in place. Resident #134 was able to reposition self in chair and asking staff to put her to bed. Resident #134 stated that she did not know what the pillow was for. She was unable to remove the lap buddy when NA #3 was putting her to bed. NA# 3 indicated that the lap buddy was used to prevent falls and resident could not remove on command. NA #3 indicated that she had not seen the resident stand up unassisted or remove the lap buddy by herself.</p> <p>During an observation on 9/7/11 at 11:00AM,, Resident #134 was seated in wheelchair in front of room with lap buddy in place. Resident #134 was using the arm rest pushing herself back in chair. Resident #134 was calling out for staff to put her to bed. Nurse #1 indicated that resident could remove the lap buddy, but when nurse asked the resident to remove the lap buddy she was unable to do so even with verbal cueing. Resident #134 just rested on the arm rest. Nurse removed the lap buddy for resident when putting her to bed.</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>During an observation on 9/7/11 at 3:30PM, Resident #134 was seated in hall with lap buddy in place at nurse's station. There was no leaning, repetitive movements or difficulty with repositioning in the chair. The lap buddy was placed at resident's knee.</p> <p>During an observation on 9/8/11 at 5:03PM, Resident #134 was seated in door way with lap buddy in place, no repetitive movements. The lap buddy was at knee level.</p> <p>During an interview on 9/8/11 at 10:28AM, the DON(director of nursing) indicated that she was responsible for the fall and restraint committee. She added that the committee had verbal discussion regarding the least restrictive device for Resident #134 based on the falls on 6/18/11 and 8/16/11. She further stated that because she knew the resident seat belt would not work, therefore she applied the lap buddy. She also stated that Resident #134 had not been referred to the physical therapy department and the lap buddy was being used for positioning, resident safety, prevention of further falls and leaning forward. In addition, Resident #134 had not been assessed for any other alternative devices or interventions and there was no formalized assessment process in which documentation was kept to determine the use of the least restrictive devices.</p> <p>During an interview on 9/8/11 at 10:58AM, NA #5 indicated that restorative ambulation consist of walking resident 50-100 ft depending on the resident program. Resident #134 was waked daily with rolling walker for 15 minutes. Resident</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>#134 has been in restorative for at least 1 yr. Resident #134 requires a 1 person assistance to stand, but she was able to ambulate with rolling walker with directional guidance and cueing. NA #5 indicated that Resident #134 was able to sit in a chair and reposition self independently. She added that Resident #134 was unable to remove the lap buddy and she had the lap buddy because Resident #134 was trying to get up independently. NA #5 indicated that she had not seen the resident get up unassisted.</p> <p>During an interview on 9/8/11 at 11:28AM, the (physical therapy assistant) PTA #1 indicated that the Pt coordinator goes to the daily meeting and discusses therapy issues and/or restraints. The PTA indicated that nursing would make the referrals for assessment for services. The PTA further stated that PT was not involved in decision to use the lap buddy for Resident #134.</p> <p>During an interview on 9/8/11 at 11:08AM, NA #6 indicated that Resident #134 needed a one person assistance to stand and use the rolling walker with minimum light hold gait assistance. NA #6 also stated that Resident #134 was able to reposition self in a chair independently and did not have any positioning concerns. In addition, Resident #134 would verbally let you know when she wanted to go to bed and the resident had the lap buddy a few months. NA #6 added that Resident #134 was unable to remove the lap buddy on command. NA #6 did not indicate that she had seen the Resident #134 get up independently.</p> <p>During an interview on 9/8/11 at 11:55AM, NA#2</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>and NA #3 indicated that Resident #134 needed a one person assistance with activities of daily living. The NA's added that encouragement was provided with staff assistance to walk to the bathroom with rolling walker. Resident was able to ambulate with little difficulty when holding onto walker. Resident #134 was able to reposition self in a chair as long as the chair had arms. Both NA 's indicated that they were unaware of Resident #134 falling from a chair or had an issue with leaning other than when she was tired or dosing off in the chair. Both NA 's indicated that Resident #134 had the lap buddy at least 6 months and it was used as a reminder for Resident #134 not to get up unassisted and for safety. Resident was unable to remove the lap buddy on command. Both nursing assistants ' indicated they were unaware of seeing the resident get up unassisted.</p> <p>During an interview on 9/8/11 at 12:15PM, the ADON, indicated that the lap buddy was for safety and positioning after reviewing the MD order. She indicated that DON handled the restraint process. She was uncertain of the determination or the restraint process and the documentation. She added after review of the nurse 's note that only one incident of which it was documented that the resident removed the lap buddy. She further added that she had not seen the resident remove the lap buddy on command or otherwise.</p> <p>During a family interview on 9/8/11 at 1:30PM, family member indicated that they had requested the use of the restraint(seat belt), but was told by the director of nursing that the seat belt would not work, therefore the lap buddy was put in place. In</p>	F 221			

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F 221	<p>Continued From page 8</p> <p>addition, The family member stated that Resident #134 did lean over when she was tired and the lap buddy was being used for positioning, safety and a place for Resident #134 to place items.</p> <p>During an interview on 9/8/11 at 5:07PM, NA #4 indicated that the lap buddy was in place cause family wanted it to prevent the resident from falling. She indicated that two weeks ago the resident did not have the lap buddy in place cause a family member want her to have it and when they found out that the resident had slid out to floor on knee, they wanted the resident to have it back. NA#4 added that Resident #134 was able to reposition self in chair and generally falls asleep in chair and that is when she leans. In addition, Resident #134 was unable to remove lap buddy and she was unaware of the resident getting up without assistance.</p> <p>During a follow-up interview on 9/9/11 at 3:23PM, the DON, indicated that the medical reason for the use of the lap buddy was because Resident #134 had weak legs, unable to stand without assistance, positioning and to improve posture and balance. She added after review of the location of the fall and fall type, that maybe the lap buddy was a restraint and should have been coded as restraint on the MDS. She further stated that since Resident #134 was observed once to remove the lap buddy that was the reason why it was not coded. She also added that the resident could not remove it on command.</p> <p>2. Resident #100 was admitted to the facility on 10/1/09, with multiple diagnoses including hypertension, hypothyroidism, organic brain syndrome dementia, depression, anxiety and</p>	F 221			

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F 221	<p>Continued From page 9</p> <p>osteoarthritis. The significant change in status assessment dated 6/29/11 indicated that the resident had memory and decision-making problems and needed extensive assistance with bathing and limited assistance with transfers and ambulation. There was no mention of restraint. The quarterly MDS (Minimum Data Set) assessment dated 8/22/11 indicated that the resident had no restraints. The MDS also revealed the resident required extensive assistance with activities of daily living, transfers, mobility, ambulatory, standing and sitting, balance, and required one-person assistance.</p> <p>The physician's order dated 1/6/11 documented: " D/c [discontinue] seatbelt to wheel chair. 2. May use ' posey hugger ' [lap buddy] in wheelchair due to positioning issues. "</p> <p>Record review of resident's incident report dated 9/6/11 documented: " pt [patient] was pulling self up to the desk wheelchair, flipped forward, pt lying supine in front of desk, lap buddy intact. Drops of blood noted beside pt. Pt leg rolled to the back, assessed for injury. "</p> <p>Review of the resident care plan dated 8/3/11 showed the resident was not care-planned for a restraint.</p> <p>Resident #100 was observed on 9/6/11 at 3:00 p.m. The resident was in her room. A lap buddy was secured to the resident's wheelchair. The resident was yelling for help.</p> <p>On 9/ 7/11 at 8:40 a.m., resident #100 was observed in her wheelchair in the dining room eating breakfast with the lap buddy in place.</p>	F 221			

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F 221	<p>Continued From page 10</p> <p>Observation revealed no attempts by the resident to get up or lean forward. The lap buddy was not removed during the meal.</p> <p>Resident #100 was observed on 9/7/11 at 4:00 p.m. at Nursing Station A propelling the wheelchair with her feet and hands. The resident was sitting upright and was able to reposition herself. A lap buddy was secured to the resident's wheelchair.</p> <p>Resident #100 was observed on 9/9/11 at 12:30 p.m. The resident was in her room with a family member. A lap buddy was secured to the resident's wheelchair. Resting on top of the lap buddy was a cup with a red drink. Nurse # 2 asked Resident #100 to remove the lap buddy the resident did not remove the lap buddy.</p> <p>During an interview on 9/9/11 at 10:42 a.m., NA# 1 indicated that the resident had several falls and the lap buddy was used as safety measure. Also her family wanted her to wear the lab buddy whenever she was out of bed.</p> <p>During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was not care-planned for a restraint because the lap buddy was not a restraint. The MDS coordinator added that the resident was given the lap buddy for safety because of her many falls.</p> <p>During interview on 9/9/11 at 3:30 p.m., DON indicated that dementia and poor safety were the medical reasons for the resident's lap buddy. She further stated that the resident was unable to walk and, because of the falls, she gave the resident the lap buddy. The DON added that she</p>	F 221			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE OF ELKIN	STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621
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F 221	<p>Continued From page 11</p> <p>did not assess the resident because the lap buddy was one of the fall precautions and the resident could release the lap buddy upon command.</p> <p>During an interview on 9/9/11 at 4:05 p.m. with the regional nurse consultant, she stated that her expectations are that all residents with a restrictive device should have a clinical diagnosis and be assessed for the least restrictive device. She added that any device that cannot be removed on the command of a nurse is a restraint.</p> <p>In an interview on 9/9/11 at 4:13 p.m., Nurse # 3 indicated she provided care for Resident #100 daily. Nurse # 3 stated " the lap buddy was given to the resident to prevent her from falling and she had it for a long time; she uses it anytime she gets out of bed. " Nurse # 3 further stated that a family member requested the lap buddy for safety measures.</p> <p>During an interview on 9/9/11 at 4:38 p.m. with NA# 10, she stated that the resident had the lap buddy for her safety whenever she was in the wheelchair. She indicated that the resident cannot walk, she needs the lap buddy for positioning, and she puts her drinks and phone on it.</p> <p>During an interview on 9/9/11 at 6:00 p.m., the Rehab Director indicated that Resident #100 had been seen by the department for chest therapy, bed mobility, and gait training; she was never referred to the department for any positioning device. The rehab director indicated that the department staff was not involved in the quarterly review process for the use or discontinuation of</p>	F 221		

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F 221	<p>Continued From page 12</p> <p>restraints. She indicated that the nurse normally implements the restrictive devices at the family's request.</p> <p>3. Resident #84 was admitted to the facility 4/24/08 with the diagnosis of dementia, hypertension and anemia.</p> <p>Review of quarterly Minimum Data Set (MDS), dated 7/11/11 indicated Resident #84 had severe short and long term memory problems, with severely impaired cognitive skills for daily decision making the MDS indicated the resident had no mood indicators with disruptive behavior during the seven day look back period. The MDS indicated the resident required extensive physical assistance of two people with activities of daily living except eating and mobility while in wheel chair. The MDS indicated Resident #84 was unsteady with gait and required staff assistance. The MDS assessment indicated that the resident had no restraints.</p> <p>Review of the physicians order dated 6/10/08, " Effective 5-26-08 per P.T. (physical therapy) recommendation -PT. to be oob (out of bed) in high back w/c(wheelchair) with lap buddy to remind pt(patient) not to get up. " A lap buddy was a thick pillow that was hooked to the wheelchair to prevent a resident from standing up. The most recent physician's order dated 8/1/11, May be up in geri chair (a wheeled recliner) for position/comfort. Fall precautions. Out of bed in reclined highback wheelchair with wedge cushion leg rests applied lap buddy with postural correction noted Wanderguard on wheel chair at all times.</p> <p>Review of the most current Restraint Initial/Annual Assessment for a Physical Device</p>	F 221			

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F 221	<p>Continued From page 13</p> <p>Form dated 1/15/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom to use the restraint was " Resident slides in w/c(wheelchair) and cannot remember to sit up d/t(due to) dementia " . Review of the most current Interdisciplinary Referral to Rehab/Quarterly Rehab Screen, dated 7/8/11, indicated change of Resident #84 condition " positioning /bed mobility " recommended occupational therapy evaluation.</p> <p>Review of an newly completed Restraint Initial/Annual Assessment for a Physical Device Form dated 9/9/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom for use of the restraint, " DX(diagnosis) muscle weakness and OA (osteoarthritis) abnormality. Res.(Resident) is not able to stand indep. (independently) safely , inc (increased) risk for falls, impaired balance. " Documented indicated no other options were attempted.</p> <p>Review of the Care Area Assessment,(CAA) dated 9/9/11, no trigger for restraints, review of the care plans revealed there was no care plan for restraints.</p> <p>During an observation on 9/9/11 at 12:45pm, Resident #84 ate her meal unassisted in the dining room. She sat in a high backed wheel chair at the table, no lap buddy a tab alarm in place (an alarm that was clipped to the residents clothing and chair that alarms when disconnected) and an wandergard alarm(this alarm sounded when breeching the exit) on her wheel chair. Her positioning was upright, no abnormality was observed.</p> <p>During an observation on 9/9/11 at 1:10pm,</p>	F 221			

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F 221	<p>Continued From page 14</p> <p>Resident #84 was sitting in the dining room with the lab buddy in place.</p> <p>During an observation on 9/9/11 at 3:06pm, Resident #84 was sitting in the hall with the lap buddy in place the assistant director of nursing (ADON) requested her to remove the lap buddy. Resident #84 was unable to remove the lap buddy despite two requests by the ADON. Resident #84 said " I can ' t it is hooked on both sides " and after the second request " I can ' t. " The care plans were reviewed. No care plan was written to address the lap buddy use as a restraint, or reduction measures which had been attempted. A care plan dated 1/31/11 indicated the problem as, Alteration ADL(activities of daily living) r/t(related to) dementia with short and long term memory loss. The goal were as follows, 1. she will assist with turning and repositions self x 90 days. 2. she will be able to wash her face, 3. she will ambulate with 2 person assist.</p> <p>The approaches the facility would use to reach those goals were *Bath/shower as scheduled *Nail Care prn*Turn as reposition as indicated *Assist with clothing changes *Plate guardwith meals, * oob(out of bed)in recliner highback w/c with wedge cushion and leg rest with lap buddy with postural correction, * feed at meal time if needed.</p> <p>Care plan #2 relating to the use of the lap buddy, dated 1/31/11,the problem was Potential for falls r/t impaired mobility she takes an antiderpressant(sic)/antipsychotic, and anxiety. She had a fall 12/3/10. The goal *No fall related injury x90 days.</p> <p>Approaches keep bed low , call light within reach, maintain safety with transfers *Tabs monitor to alert staff and to remind patient not to set up unassisted *</p>	F 221			

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F 221	<p>Continued From page 15</p> <p>Bed in low position at all times(it was written twice), *Lap buddy in chair to aid in position with high back w.c * Bring out of room if restless. * Monitor s/sx (signs and symptoms) uti (urinary tract infection) check lap buddy frequesnt ly as she can remove it</p> <p>3/27/11 Fall, keep in view of staff when up in w/c</p> <p>3/31/11 Add to active occ program (a program in which falls are monitored for a month) 4/10/11 Fall, Redirect if resident goes off unit.</p> <p>5/17/11 Fall, toilet after supper.</p> <p>During an interview with the Director of Nursing on 9/9/11 at 1:10pm, revealed Resident #84 used her lap buddy for positioning and to set her coffee on it. She indicated the resident was not able to get up by herself and could not walk and was able to remove the lap buddy. She revealed the wandergard would lock the outside door within 6 feet of the exit if the door were shut, if the door was open the alarm would sound. She also indicted the tab alarm was in place to prevent falls.</p> <p>During an interview on 9/9/11 at 2:48pm, NA# 7 indicated the lap buddy kept her from falling out of the wheelchair. She explained Resident #84 cannot get out of her chair or walk , but she can slide out of the wheelchair. A blue cushion in the chair and a sticky diycem put between the cushion and the chair prevented Resident #84 from sliding out of the chair, she indicated she thought the resident was a fall risk.</p> <p>During an interview on 9/9/11 at 2:54pm, NA#8 indicated the primary reason for the lap buddy was to keep her from sliding out of the chair. If she had no lap buddy she would scoot out of the</p>	F 221			

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F 221	<p>Continued From page 16</p> <p>chair. The personal alarm doesn't go off until she leans really far forward or she stands. NA#8 indicated Resident #84 doesn't stand well even with two people assisting her, and resident was unable to get up unassisted. She has not had any recent falls.</p> <p>During an interview on 9/9/11 at 3:14 pm, NA# 9 indicated she had never seen Resident #84 remove her lap buddy. She indicated the purpose of the lap buddy was to keep her from sliding out of the wheel chair. She indicated there was another cushion in the chair to keep her in the chair, she indicated even with the lap buddy Resident #84 would slide under it up to her breast and indicated the resident was unable to stand or ambulate.</p> <p>During an interview on 9/9/11 at 3:30 pm, the physical therapy manager revealed Resident #84 sacral sits, (sits on her lower back and arches her back) to prevent sliding she currently had in place a wedge cushion which was higher in the front and lower in the back and a high back chair making it harder for her to slip out of the chair when she arches her back. This adaptive equipment did not prevent the sliding from sacral sitting, the lap buddy was an alternative, not the best alternative. Resident #84 was a good candidate for a broda chair (a low sitting reclined wheeled chair). She indicated she was unsure as to the reason the facility was unable to obtain a broda chair.</p> <p>During an interview on 9/9/11 at 4:35pm, NA #10 indicated the lap buddy was used to keep Resident #84 in her chair and that the resident was unable to get up out of her wheel chair or</p>	F 221			

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F 221	Continued From page 17 walk without staff assistance. She had not seen her remove it; she indicated Resident #84 unzips it, thinking it is her purse. During an interview on 9/9/11 at 4:59pm, the occupational therapist indicated Resident #84 sacral sits, (sits on the lower back) and a broda chair would be most appropriate. The facility doesn't have this type of chair the lap buddy was the facilities alternative.	F 221	1. Corrective action has been accomplished for the alleged deficient practice for Residents # 134,100, and 84 through reevaluation and reassessment of the necessity for physical devices. Based on the reassessments, the use of physical devices was determined based on individual resident needs and such determinations recorded appropriately in the clinical record.	9-22-11
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	2. Residents with the potential to be affected by the alleged deficient practice were identified through 100% audit of residents with an assessed need for safety devices. All residents with safety devices in place were reassessed with assessments documented, the least restrictive device implemented, and individual care plans and physician's orders amended to accurately reflect changes.	

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F 272	<p>Continued From page 18</p> <p>Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a full assessment for restraint RAP's (resident assessment protocols) that were triggered for 3 of 4 resident's (Residents # 134, #100 and #84). The findings include:</p> <p>1. Resident #134 was admitted to the facility on 11/5/09. Resident #134 cumulative diagnoses included dementia, cerebral vascular accident, congestive heart failure, general muscle weakness and degenerative joint disease. The quarterly Minimum Data Set (MDS) dated 8/17/11, indicated that Resident #134 had severe short and long term memory and decision making problems. Section P of the MDS was not coded for the use of restraint.</p> <p>The CAT (care area triggers) worksheet dated 8/17/11, (restraints) notes indicated that Resident #134 did not have a lap buddy in place in her wheelchair. There was nothing checked under the "Care Planning decision " section of the page.</p>	F 272	<p>The results of monitoring will be reviewed weekly in morning meeting and monthly during PI meetings. Adjustments will be implemented as necessary based on the results of monitoring to ensure compliance.</p>	10/13/11	

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F 272	<p>Continued From page 19</p> <p>In addition, under each individual RAP worksheet for each triggered RAP, there was no indication whether the identified problem was to be included in the care plan.</p> <p>During an interview on 9/9/11 at 1:10PM, the MDS coordinator indicated that when she assessed the resident the lap buddy was in place and the restraint assessment had been done on 8/7/11. She added that the resident and the family indicated they wanted the lap buddy. She further added that the restraint was not coded on the MDS because the team did not determine the lap buddy was a restraint. She indicated that she had not seen the resident remove the lap buddy, only seen the resident lean on the lap buddy. She added that use and frequency of the lap buddy was not care plan because it was not coded as restraint. Therefore, the care area triggers were not done.</p> <p>2. Resident #100 was admitted to the facility on 10/1/09, with multiple diagnoses including hypertension, hypothyroidism, organic brain syndrome dementia, depression, anxiety and osteoarthritis. The significant change in status assessment dated 6/29/11 indicated that the resident had memory and decision-making problems and needed extensive assistance with bathing and limited assistance with transfers and ambulation. There was no mention of restraint. The quarterly MDS (Minimum Data Set) assessment dated 8/22/11 indicated that the resident had no restraints. The MDS also revealed the resident required extensive assistance with activities of daily living, transfers, mobility, ambulatory, standing and sitting, balance, and required one-person assistance.</p>	F 272		

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F 272	<p>Continued From page 20</p> <p>The physician's order dated 1/6/11 documented: " D/c [discontinue] seatbelt to wheel chair. 2. May use [lap buddy] in wheelchair due to positioning issues. "</p> <p>Review of the resident care plan dated 8/3/11 showed the resident was not care-planned for a restraint. The CAT (care area triggers) worksheet dated 8/3/11, (restraints) notes indicated that Resident #100 did not have a lapbuddy in place in her wheelchair. There was nothing checked under the " Care Planning decision " section of the page. In addition, under each individual RAP worksheet for each triggered RAP, there was no indication whether the identified problem was to be included in the care plan.</p> <p>Resident #100 was observed on 9/9/11 at 12:30 p.m. The resident was in her room with a family member. A lap buddy was secured to the resident's wheelchair. Resting on top of the lap buddy was a cup with a red drink. Nurse # 2 asked Resident #100 to remove the lap buddy the resident did not remove the lap buddy.</p> <p>During an interview on 9/9/11 at 10:42 a.m., NA# 1 indicated that the resident had several falls and the lap buddy was used as safety measure. Also her family wanted her to wear the lab buddy whenever she was out of bed</p> <p>During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was not assessed for a restraint because the lap buddy is not a restraint. The MDS coordinator added that the resident was given the lapbuddy for safety because of her many falls. She added that the family indicated they wanted the lap</p>	F 272			

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F 272	<p>Continued From page 21</p> <p>buddy. She further added that the restraint was not coded on the MDS because the team did not determine the lap buddy was a restraint.</p> <p>During interview on 9/9/11 at 3:30 p.m., DON indicated that dementia and poor safety were the medical reasons for the resident's lap buddy. She further stated that the resident was unable to walk and, because of the falls, she gave the resident the lap buddy. The DON added that she did not assess the resident because the lap buddy was one of the fall precautions.</p> <p>3. Resident #84 was admitted to the facility 4/24/08 with the diagnosis of dementia, hypertension and anemia.</p> <p>Review of quarterly Minimum Data Set (MDS), dated 7/11/11 indicated Resident #84 had severe short and long term memory problems; with severely impaired cognitive skills for daily decision making. The MDS section " G " indicated she required extensive assistance transferring, walking, dressing, toilet use, personal hygiene and bathing and one person assist locomotion on the unit, eating, transfer on and off the toilet and between surfaces. Section P, indicated " 0 " , no restraints were in use.</p> <p>Review of the physician's order dated 6/10/08, " Effective 5-26-08 per P.T. (physical therapy) recommendation -PT. to be oob (out of bed) in high back w/c (wheelchair) with lap buddy to remind pt (patient) not to get up. " A lap buddy was a thick pillow that was hooked to the wheelchair to prevent a resident from standing up</p> <p>The most recent physician's order dated 8/1/11, May be up in geri chair (a wheeled recliner) for position/comfort. Fall precautions. Out of bed in reclined highback wheelchair with wedge cushion leg rests applied lap buddy with postural</p>	F 272			

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F 272	<p>Continued From page 22</p> <p>correction noted Wanderguard on wheel chair at all times.</p> <p>Review of the most current Restraint Initial/Annual Assessment for a Physical Device Form dated 1/15/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom to use the restraint was " Resident slides in w/c (wheelchair) and cannot remember to sit up d/t (due to) dementia " and indicated Resident #84 was incontinent of bowel and bladder.</p> <p>Care plan dated 1/31/11, problem identified alternation in ADL level related to dementia with short and long term memory loss. Approach, OOB in recliner high back wheelchair with wedge cushion and leg rest with lap buddy with postural correction.</p> <p>Care plan dated 1/31/11, problem identified potential for falls due to impaired mobility and a fall a 12/3/10. Approaches included, lap buddy in chair to aid in positioning with high back wheelchair.</p> <p>Review of a newly completed Restraint Initial/Annual Assessment for a Physical Device Form dated 9/9/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom for use of the restraint, " DX(diagnosis) muscle weakness and OA(osteoarthritis) abnormality. Res. (Resident) is not able to stand indep. (independently) safely, inc (increased) risk for falls, impaired balance " and indicated Resident #84 was incontinent of bowel and bladder.</p> <p>Review of the Care Area Assessment,(CAA) dated 9/9/11, did not identify Resident #84 for restraints, review of the care plans revealed there was no care plan for restraints.</p> <p>During an observation on 9/9/11 at 3:06pm,</p>	F 272		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345124	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2011
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE OF ELKIN			STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621	
(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 272	Continued From page 23 Resident #84 was sitting in the hall with the lap buddy in place the assistant director of nursing (ADON) requested her to remove the lap buddy. Resident #84 was unable to remove the lap buddy despite two requests by the ADON. Resident #84 said " I can ' t it is hooked on both sides " and after the second request " I can't. " During an interview on 9/9/11 at 2:48pm, NA# 7 indicated the lap buddy kept her from falling out of the wheelchair. She explained Resident #84 cannot get out of her chair or walk, but she can slide out of the wheelchair. A blue cushion in the chair and diycem (a sticky pad to prevent slipping) put between the cushion and the chair prevented Resident #84 from sliding out. During an interview on 9/9/11 at 2:54pm, NA#8 indicated the primary reason for the lap buddy was to keep her from sliding out of the chair. If she had no lap buddy she would scoot out of the chair. The personal alarm doesn ' t go off until she leans really far forward or she stands. NA#8 indicated Resident #84 doesn ' t stand well even with two people assisting her. During an interview on 9/9/11 at 3:14 pm, NA# 9 indicated she had never seen Resident #84 remove her lap buddy. She indicated the purpose of the lap buddy was to keep her from sliding out of the wheel chair. She indicated there was another cushion in the chair to keep her in the chair, she indicated even with the lap buddy Resident #84 would slide under it up to her breast and indicated the resident was unable to stand or ambulate. During an interview on 9/9/11 at 4:35pm, NA #10 indicated the lap buddy was used to keep Resident #84 in her chair and that the resident was unable to get up out of her wheel chair or walk without staff assistance. She had never seen her remove it.	F 272		

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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE OF ELKIN			STREET ADDRESS, CITY, STATE, ZIP CODE 660 JOHNSON RIDGE RD ELKIN, NC 28621	
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F 272	Continued From page 24 During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was not assessed for a restraint because the lap buddy was not a restraint; it was used to keep her in the wheelchair. During an interview on 9/9/11 at 5:37pm, at the MDS coordinator indicated she had intertwined the lap buddy in the care plan with falls and cognitive impairment, and did not asses the lap buddy as a restraint.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a	F 278	Corrective action has been accomplished for the alleged deficient practice for Residents # 134,100, and 84 through reevaluation and reassessment of the necessity for physical devices. Based on the reassessments, the use of physical devices was determined based on individual resident needs and such determinations recorded appropriately in the clinical record. Residents with the potential to be affected by the alleged deficient practice were identified through 100% audit of residents with an assessed need for safety	9-22-11 9-22-11

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F 278	<p>Continued From page 25 material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to accurately code information on the Minimum Data Set (MDS) assessments for 3 of 4 residents with restraints(Residents #134, #100 and #84).</p> <p>Findings include:</p> <p>1. Resident #134 was admitted to the facility on 11/5/09. Resident #134 cumulative diagnoses included dementia, cerebral vascular accident, congestive heart failure, general muscle weakness and degenerative joint disease. The quarterly Minimum Data Set (MDS) dated 8/17/11, indicated that Resident #134 had severe short and long term memory and decision making problems. Section P of the MDS was not coded for the use of restraint.</p> <p>The physician's order dated 8/7/11, documented lap buddy for safety and positioning. There was no medical symptom indicated. Resident #134 has been in restorative ambulation 15 minutes per day since January 2010. There was only on unobserved fall on 6/18/11.</p> <p>The CAT (care area triggers) worksheet dated 8/17/11, (restraints) notes indicated that Resident #134 did not have a lap buddy in place in her wheelchair.</p> <p>During an interview on 9/9/11 at 1:10PM, the MDS coordinator indicated that when she</p>	F 278	<p>devices. All residents with safety devices in place were reassessed with assessments documented, the least restrictive device implemented, and individual care plans and physician's orders inconsistencies or problems with device use.</p> <p>The results of monitoring will be reviewed weekly in morning meeting and monthly during PI meetings. Adjustments will be implemented as necessary based on the results of monitoring to ensure compliance.</p>	<p>9-22-11</p> <p>10-13-11</p>	

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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE OF ELKIN	STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621
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F 278	<p>Continued From page 26</p> <p>assessed the resident on 8/17/11, the lap buddy was in place and the restraint assessment had been done on 8/7/11. She added that the resident and the family indicated they wanted the lap buddy. She further added that the restraint was not coded on the MDS because the team did not determine the lap buddy was a restraint. She indicated that she had not seen the resident remove the lap buddy, only seen the resident lean on the lap buddy. She added that use and frequency of the lap buddy was not care plan because it was not coded as restraint. Therefore, the care area triggers were not done. The problem area under falls indicated that Resident #134 had a lap buddy in place for positioning and for placing her cup on.</p> <p>2. Resident #100 was admitted to the facility on 10/1/09, with multiple diagnoses including hypertension, hypothyroidism, organic brain syndrome dementia, depression, anxiety and osteoarthritis. The significant change in status assessment dated 6/29/11 indicated that the resident had memory and decision-making problems and needed extensive assistance with bathing and limited assistance with transfers and ambulation. There was no mention of restraint. The quarterly MDS (Minimum Data Set) assessment dated 8/22/11 indicated that the resident had no restraints. The MDS also revealed the resident required extensive assistance with activities of daily living, transfers, mobility, ambulatory, standing and sitting, balance, and required one-person assistance. There was no mention of restraint.</p> <p>The physician's order dated 1/6/11 documented: " D/c [discontinue] seatbelt to wheel chair. 2. May</p>	F 278		

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F 278	<p>Continued From page 27</p> <p>use [lap buddy] in wheelchair due to positioning issues. "</p> <p>Review of the medial record revealed a quarterly MDS assessment 8/2/11. Under the MDS, section "PO100. Physical Restraint " trunk," the facility indicated, "0". None.</p> <p>Resident #100 was observed on 9/9/11 at 12:30 p.m. The resident was in her room with a family member. A lap buddy was secured to the resident's wheelchair. Resting on top of the lap buddy was a cup with a red drink. Nurse # 2 asked Resident #100 to remove the lap friend, the resident could not remove the lap buddy.</p> <p>During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was coded " O " for a trunk restraint because the lap buddy is not a restraint. The MDS coordinator added that the resident was given the lap buddy for safety because of her many falls.</p> <p>3. Resident #84 was admitted to the facility 4/24/08 with the diagnosis of dementia, hypertension and anemia.</p> <p>Review of quarterly Minimum Data Set (MDS), dated 7/11/11 indicated Resident #84 had severe short and long term memory problems; with severely impaired cognitive skills for daily decision making. The MDS section " G " indicated she required extensive assistance transferring, walking, dressing, toilet use, personal hygiene and bathing and one person assist locomotion on the unit, eating, transfer on and off the toilet and between surfaces. Section P, indicated " 0 ", no restraints were in use.</p> <p>Review of the physician's order dated 6/10/08, " Effective 5-26-08 per P.T. (physical therapy)</p>	F 278			

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F 278	Continued From page 28 recommendation -PT. to be oob (out of bed) in high back w/c (wheelchair) with lap buddy to remind pt (patient) not to get up. " A lap buddy was a thick pillow that was hooked to the wheelchair to prevent a resident from standing up. The most recent physician's order dated 8/1/11, May be up in geri chair (a wheeled recliner) for position/comfort. Fall precautions. Out of bed in reclined highback wheelchair with wedge cushion leg rests applied lap buddy with postural correction noted Wanderguard on wheel chair at all times. Review of the most current Restraint Initial/Annual Assessment for a Physical Device Form dated 1/15/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom to use the restraint was " Resident slides in w/c (wheelchair) and cannot remember to sit up d/t (due to) dementia " and indicated Resident #84 was incontinent of bowel and bladder. Care plan dated 1/31/11, problem identified alternation in ADL level related to dementia with short and long term memory loss. Approach, OOB in recliner high back wheelchair with wedge cushion and leg rest with lap buddy with postural correction. Care plan dated 1/31/11, problem identified potential for falls due to impaired mobility and a fall a 12/3/10. Approaches included, lap buddy in chair to aid in positioning with high back wheelchair. Review of an newly completed Restraint Initial/Annual Assessment for a Physical Device Form dated 9/9/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom for use of the restraint, " DX(diagnosis) muscle weakness and OA(F 278		

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F 278	Continued From page 29 osteoarthritis) abnormality. Res. (Resident) is not able to stand indep. (independently) safely, inc (increased) risk for falls, impaired balance " and indicated Resident #84 was incontinent of bowel and bladder. Review of the Care Area Assessment,(CAA) dated 9/9/11, did not identify Resident #84 for restraints, review of the care plans revealed there was no care plan for restraints. During an observation on 9/9/11 at 3:06pm, Resident #84 was sitting in the hall with the lap buddy in place the assistant director of nursing (ADON) requested her to remove the lap buddy. Resident #84 was unable to remove the lap buddy despite two requests by the ADON. Resident #84 said " I can ' t it is hooked on both sides " and after the second request " I can't. " During an interview on 9/9/11 at 2:48pm, NA# 7 indicated the lap buddy kept her from falling out of the wheelchair. She explained Resident #84 cannot get out of her chair or walk, but she can slide out of the wheelchair. A blue cushion in the chair and diycem (a sticky pad to prevent slipping) put between the cushion and the chair prevented Resident #84 from sliding out. During an interview on 9/9/11 at 2:54pm, NA#8 indicated the primary reason for the lap buddy was to keep her from sliding out of the chair. If she had no lap buddy she would scoot out of the chair. The personal alarm doesn't go off until she leans really far forward or she stands. NA#8 indicated Resident #84 doesn ' t stand well even with two people assisting her. During an interview on 9/9/11 at 3:14 pm, NA# 9 indicated she had never seen Resident #84 remove her lap buddy. She indicated the purpose of the lap buddy was to keep her from sliding out of the wheel chair. She indicated there was another cushion in the	F 278		

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F 278	Continued From page 30 chair to keep her in the chair, she indicated even with the lap buddy Resident #84 would slide under it up to her breast and indicated the resident was unable to stand or ambulate. During an interview on 9/9/11 at 4:35pm, NA #10 indicated the lap buddy was used to keep Resident #84 in her chair and that the resident was unable to get up out of her wheel chair or walk without staff assistance. She had never seen her remove it. During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was not assessed for a restraint because the lap buddy was not a restraint; it was used to keep her in the wheelchair. During an interview on 9/9/11 at 5:37pm, at the MDS coordinator indicated she had intertwined the lap buddy in the care plan with falls and cognitive impairment, and did not asses the lap buddy as a restraint.	F 278			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280			

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F 280	<p>Continued From page 31 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews, the facility failed to revised care plan for 4 of 4 residents with restraints as evidence by not including the frequency for the use of the restraint (Resident #134, #100, #84). The findings included</p> <p>1. Resident #134 was admitted to the facility on 11/5/09. Resident #134 cumulative diagnoses included dementia, cerebral vascular accident, congestive heart failure, general muscle weakness and degenerative joint disease. The quarterly Minimum Data Set (MDS) dated 8/17/11, indicated that Resident #134 had severe short and long term memory and decision making problems. The MDS also indicated that Resident #134 was hard of hearing and required the use of an assistive device and still had difficulty understanding verbal content and reminders to help make sense of the things even when voice tone was not at an elevated volume in one ear. Section P of the MDS was not coded for the use of restraint. Resident #134 was involved in a toileting program and had made some progress, but needed assistance with transfers and ambulation.</p> <p>The physician's order dated 8/7/11, documented lap buddy for safety and positioning. There was no medical symptom indicated. Resident #134</p>	F 280		

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F 280	<p>Continued From page 32</p> <p>has been in restorative ambulation 15minutes per day since January 2010.</p> <p>Review of the care plan dated 8/22/11, identified the problem as: 1. potential for falls r/t(related to falls on 6/18/11(unobserved fall, Resident was found in room on floor) and 8/16/11staff was present in resident room she took off her lap buddy and stood up without assistance, gait unsteady, balance is impaired. The goal was Resident #134 will have no falls r/t(related to) injuries x 90 days. The approaches included remind resident to call for assist with transfers and/or ambulation, keep bed in low position at all times, call light within reach, maintain safety with transfers, remind resident to call for assist with transfers and to use her walker with ambulation, lap buddy. 2. Decline in ability to ambulate independently. The goal included Resident #134 will ambulate 50-125 ft daily x 90 days. The approach included the rolling walker with supervision and verbal cues to stand up tall stay close to rolling walker, monitor and document program. There was no indication on the care plan of the frequency and duration of use for the lap buddy.</p> <p>During an interview on 9/9/11 at 1:10PM, the MDS coordinator indicated that when she assessed the resident the lap buddy was in place and the restraint assessment had been done on 8/7/11. She added that the resident and the family indicated they wanted the lap buddy. She further added that the restraint was not coded on the MDS because the team did not determine the lap buddy was a restraint. She indicated that she had not seen the resident remove the lap buddy, only seen the resident lean on the lap buddy. She</p>	F 280		

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F 280	<p>Continued From page 33</p> <p>added that use and frequency of the lap buddy was not care plan because it was not coded as restraint. Therefore, the care area triggers were not done. The lap buddy was in place for positioning and a place for Resident #134 to place items.</p> <p>2. Resident #100 was admitted to the facility on 10/1/09, with multiple diagnoses including hypertension, hypothyroidism, organic brain syndrome dementia, depression, anxiety and osteoarthritis. The quarterly MDS (Minimum Data Set) assessment dated 8/22/11 indicated that the resident had no restraints. The MDS also revealed the resident required extensive assistance with activities of daily living, transfers, mobility, ambulatory, standing and sitting, balance, and required one-person assistance. The significant change in status assessment dated 6/29/11 indicated that the resident had memory and decision-making problems and needed extensive assistance with bathing and limited assistance with transfers and ambulation. There was no mention of restraint.</p> <p>The physician's order dated 1/6/11 documented: " D/c [discontinue] seatbelt to wheel chair. 2. May use ' Posey hugger ' [lap buddy] in wheelchair due to positioning issues. "</p> <p>Review of the resident care plan dated 8/3/11 showed the resident was not care-planned for a restraint.</p> <p>Resident #100 was observed on 9/6/11 at 3:00 p.m. The resident was in her room. A lap buddy was secured to the resident's wheelchair.</p> <p>On 9/ 7/11 at 8:40 a.m., resident #100 was</p>	F 280			

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F 280	<p>Continued From page 34</p> <p>observed in her wheelchair in the dining room eating breakfast with the lap buddy in place. Observation revealed no attempts by the resident to get up or lean forward. The lap buddy was not removed during the meal.</p> <p>Resident #100 was observed on 9/7/11 at 4:00 p.m. at Nursing Station A propelling the wheelchair with her feet and hands. The resident was sitting upright and was able to reposition herself. A lap buddy was secured to the resident's wheelchair.</p> <p>Resident #100 was observed on 9/9/11 at 12:30 p.m. The resident was in her room with a family member. A lap buddy was secured to the resident's wheelchair. Resting on top of the lap buddy was a cup with a red drink. Nurse # 2 asked Resident #100 to remove the lap buddy. The resident did not remove the lap buddy.</p> <p>During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was not care-planned for a restraint because the lap buddy is not a restraint because the resident is capable of removing the lap buddy. The MDS coordinator added that the resident was given the lap buddy for safety because of her many falls.</p> <p>4. Resident #84 was admitted to the facility 4/24/08 with the diagnosis of dementia, hypertension and anemia.</p> <p>Review of Minimum Data Set (MDS), dated 7/11/11 indicated Resident #84 had severe short and long term memory problems; with severely impaired cognitive skills for daily decision making. The MDS section " G " indicated she required extensive assistance transferring, walking,</p>	F 280		

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F 280	<p>Continued From page 35</p> <p>dressing, toilet use, personal hygiene and bathing and one person assist locomotion on the unit, eating, transfer on and off the toilet and between surfaces. Mobility devices included a walker and wheelchair. Section H indicated always incontinent of bladder. Section I indicated always continent of bowel. Section J, indicated no falls. Section P, indicated "0", no restraints were in use.</p> <p>Review of the physician's order dated 6/10/08, " Effective 5-26-08 per P.T. (physical therapy) recommendation -PT. to be oob (out of bed) in high back w/c (wheelchair) with lap buddy to remind pt (patient) not to get up. " A lap buddy was a thick pillow that was hooked to the wheelchair to prevent a resident from standing up.</p> <p>Review of the most current Restraint Initial/Annual Assessment for a Physical Device Form dated 1/15/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom to use the restraint was " Resident slides in w/c (wheelchair) and cannot remember to sit up d/t (due to) dementia " and indicated Resident #84 was incontinent of bowel and bladder.</p> <p>Care plan dated 1/31/11, problem identified alternation in ADL level related to dementia with short and long term memory loss. Approach, OOB in recliner high back wheelchair with wedge cushion and leg rest with lap buddy with postural correction.</p> <p>Care plan dated 1/31/11, problem identified potential for falls due to impaired mobility and a</p>	F 280		
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F 280	<p>Continued From page 36</p> <p>fall a 12/3/10. Approaches included, lap buddy in chair to aid in positioning with high back wheelchair.</p> <p>Review of an newly completed Restraint Initial/Annual Assessment for a Physical Device Form dated 9/9/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom for use of the restraint, " DX(diagnosis) muscle weakness and OA(osteoarthritis) abnormality. Res. (Resident) is not able to stand indep. (independently) safely, inc (increased) risk for falls, impaired balance " and indicated Resident #84 was incontinent of bowel and bladder.</p> <p>Review of the Care Area Assessment,(CAA) dated 9/9/11, did not identify Resident #84 for restraints, review of the care plans revealed there was no care plan for restraints.</p> <p>During an observation on 9/9/11 at 3:06pm, Resident #84 was sitting in the hall with the lap buddy in place the assistant director of nursing (ADON) requested her to remove the lap buddy. Resident #84 was unable to remove the lap buddy despite two requests by the ADON. Resident #84 said ".I can 't it is hooked on both sides " and after the second request " I can't. "</p> <p>During an interview on 9/9/11 at 2:48pm, NA# 7 indicated the lap buddy kept her from falling out of the wheelchair. She explained Resident #84 cannot get out of her chair or walk, but she can slide out of the wheelchair. A blue cushion in the chair and a sticky diycem put between the cushion and the chair prevented Resident #84 from sliding out.</p>	F 280		

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F 280	Continued From page 37 During an interview on 9/9/11 at 2:54pm, NA#8 indicated the primary reason for the lap buddy was to keep her from sliding out of the chair. If she had no lap buddy she would scoot out of the chair. The personal alarm doesn't go off until she leans really far forward or she stands. NA#8 indicated Resident #84 doesn't stand well even with two people assisting her. During an interview on 9/9/11 at 3:14 pm, NA# 9 indicated she had never seen Resident #84 remove her lap buddy. She indicated the purpose of the lap buddy was to keep her from sliding out of the wheel chair. She indicated there was another cushion in the chair to keep her in the chair, she indicated even with the lap buddy Resident #84 would slide under it up to her breast and indicated the resident was unable to stand or ambulate. During an interview on 9/9/11 at 4:35pm, NA #10 indicated the lap buddy was used to keep Resident #84 in her chair and that the resident was unable to get up out of her wheel chair or walk without staff assistance. She had not seen her remove it. During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was not assessed for a restraint because the lap buddy was not a restraint. During an interview on 9/9/11 at 5:37pm, at the MDS coordinator indicated she had intertwined the lap buddy in the care plan with falls and cognitive impairment, and did not asses the lap buddy as a restraint.	F 280		
F 371 SS=D	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 38</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews, and record reviews, the facility 1) failed to air-dry bowls, and 2) failed to keep cold food temperatures at the appropriate temperature in the walk-in refrigerator.</p> <p>Findings included:</p> <p>During the kitchen observation on 9/8/11 at 11:40 a.m., 2 racks of pink bowls and 3 racks of green bowls were observed stacked on top of each other on a cart in the dish room area in the kitchen. Water was running off the bowls. The dietary manager acknowledged the condition of the bowls, saying that they were clean, wet, and ready to be used.</p> <p>In an interview with the dietary aide on 9/8/11 at 11:42 a.m., she stated, " I do not know who stored the bowls wet on the cart."</p> <p>During the tray line observation on 9/8/11 at 11:53 a.m., there was no food for the residents on the tray line. Upon further inspection, tuna salad and pasta salads (foods prepared for</p>	F 371	<p>Heritage Healthcare of Elkin will procure food from sources</p> <p>Approved or considered satisfactory by Federal, State, or</p> <p>Local authorities and will store, prepare, distribute and serve food</p> <p>Under sanitary conditions</p> <p>Per dietary manager the bowls were air drying on the rack and were not</p> <p>Used until they were completely dry. (Did not need for noon meal)</p> <p>CDM will re-educate dietary staff on proper drying techniques and</p> <p>Importance of not using until dishes is completely dry.</p> <p>The CDM and or designee will monitor for compliance on daily basis</p> <p>For 4 weeks then randomly thereafter.</p> <p>The findings will be taken to PI committee monthly times two</p>	<p>9-8-11</p> <p>10-14-11</p> <p>10-13-11</p>
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F 371	<p>Continued From page 39</p> <p>9/8/11 lunch) were observed in the walk-in refrigerator and freezer. The digital thermometer was calibrated. The temperatures recorded at 11:55 a.m. were 46 degrees F for tuna salad, and 58 degrees F for the pasta salad. The temperatures were rechecked immediately as the DM observed. The temperature remained at the same for the tuna salad and pasta salad. Further observations were made, and a large bowl of tuna salad was observed in the freezer with a thermometer in the middle of the tuna salad. The recorded temperature was 44 degrees F for the tuna salad. At 12:15 p.m., the temperatures were rechecked: the tuna salad was 44 degrees F, and the pasta salad was 55 degrees F.</p> <p>In an interview on 9/8/11 at 12:30 p.m. with the DM, she stated that the tuna salad and the pasta salad temperatures should be 40 degrees or below. She added that she does not know what happened. She added, " I believe the digital thermometers (facility thermometers) in kitchen are recording incorrect temperatures."</p>	F 371	<p>The tuna and pasta salad was discarded and alternate substitute</p> <p>Used in its place for lunch. The digital thermometers were discarded and</p> <p>Regular thermometers are now in use in dietary dept.</p> <p>CDM and or designee will monitor food temps carefully and temps will</p> <p>Be recorded for each meal on temp log</p> <p>Findings will be taken to the PI committee for followup monthly times three</p>	<p>9-8-11</p> <p>9-8-11</p> <p>9-8-11</p> <p>Only</p> <p>10-13-11</p>
F 456 SS=D	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview with fire department and staff interviews, the facility failed to ensure the oxygen concentrators and heating/air conditioning (HVAC) units were in safe, operating condition after 1 of 1 incidents</p>	F 456		

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F 456	<p>Continued From page 40 (room # 112, Resident # 100). Findings included.</p> <p>During an observation on tour of the facility on 9/6/11 at 2:00 p.m., the baseboard in Room 112 was torn away from the wall, and there was a hole in the wall. The oxygen concentrator had a red lock (meaning do not use) on it, and the nebulizer was unplugged.</p> <p>In an interview on 9/6/11 at 1:30 p.m. with Nursing Assistant (NA #1), she stated, " I heard a noise. Then the smoke alarm went off, and the call light for Resident #100 came on. I went into Resident #100 ' s room. The smoke alarm was on. There was the smell of something burning, and the wall close to Resident #100 ' s oxygen concentrator (O2 concentrator) was hot. I immediately turned off the resident ' s O2 concentrator. I got her out of the room and told the other employees what was going on. I immediately sounded the fire alarm and announced Code Red. All the residents in that area were evacuated, and the fire department came and inspected the room. "</p> <p>In an interview on 9/6/11 at 1:45 p.m. with the interim Director of Nursing (DON), she stated that there was a smell of something burning in the resident ' s room (Room 112), and all the residents in that area were evacuated to the dining area. Families for the residents in Room 112 were notified that there was a malfunction with the equipment in the room, which triggered the smoke alarm, and the residents were moved to another room. " When asked by the surveyor if all the other oxygen concentrators were checked, she said, " I do not know; I believe housekeeping</p>	F 456	<p>Staff upon noticing hot smell in room immediately removed patients 9-5-11</p> <p>From room, pulled fire alarm, called 911 and secured room. 9-5-11</p> <p>Each of the older PTAC units have been replaced with new units 9-22-11</p> <p>PTAC units have been cleaned to minimize possible activation of 9-22-11</p> <p>Smoke detectors, filters changed monthly on-going</p> <p>Educate staff, families and patients for smell when unit is first turned on 10-14-11</p> <p>And how it may set off the smoke detector in room due to sensitivity of alarm</p> <p>Maintenance Supervisor keeps log of when units are cleaned and filters changed on-going</p> <p>Random audits performed by administrator and or designee</p> <p>Findings will be taken to PI monthly times three 10-18-11</p>

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F 456	<p>Continued From page 41</p> <p>would do that when they clean the rooms. "</p> <p>In an interview on 9/6/11 at 2:00 p.m. with the Medical Record Manager and Dietary Manager/Housekeeping Manager, they stated that they heard the fire alarm sound and were called to Room 112 by NA #1 with the report of the smoke detector going off in the residents ' room. " We went to the room and we smelled something hot, [so] we got the other residents out of the room. We reentered the room [Room 112] and unplugged the heater and the nebulizer. Code Red was announced all over the facility and the alarm was sounding. The Maintenance Director came in and turned off the power in the room. The fire department arrived a couple minutes later and tore the wall open, because the wall was hot to the touch in the room [Room 112]. " They (the Medical Record Personnel and Dietary Manager/Housekeeping Manager) added that the wall on the other side was also hot, and the residents were removed from the room.</p> <p>In an interview on 9/6/11 at 2:30 p.m. with the Maintenance Director, he stated, " on 9/5/11 [he was not sure about the time], the fire alarm went off, and I promptly went to the nearest fire extinguisher, then I went to Nursing Station A. The nurses directed me to Room 112. I smelled a burning smell in the room, the wall adjacent to Room 112 was hot, and the floor close to the O2 concentrator was hot. I turned the receptacle breaker off. The fire department came, and they believe the resident ' s privacy curtain was too close to the O2 concentrator and triggered the heat. " The Maintenance Director added that the other O2 concentrators were not checked, " because they were rented equipment and the</p>	F 456		

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F 456	<p>Continued From page 42</p> <p>distributor had to come out and check them. They will be coming out 9/9/11. "</p> <p>During a follow-up interview on 9/6/11 at 3:15 p.m. the Maintenance Director, stated he believed that " because the heater was turned on for the first time for the summer and the heating elements were not cleaned, the burning smell came from the elements and sounded the alarm." He further added that if the heaters were not used during the summer, " when they are turned on, they will have a burning smell to the point where it can trigger the smoke alarm.</p> <p>In an interview on 9/6/11 at 3:30 p.m., the administrator stated, " Nothing happened; the smoke alarm went off, there was a malfunction of the equipment and my staff immediately evacuated the residents to a safe place and the fire department came. No one was in the room using the O2 concentrator at that time. "</p> <p>During an interview on 9/7/11 at 12:07 p.m. with the Chief of the Fire Department, stated that on 9/5/11 he responded to a call from the facility that someone smelled smoke and the smoke alarm was sounded in the facility. The fire department was advised by staff that " an odor of something burning had been detected in the residents ' room and that maintenance had noticed that the electrical outlet faceplate appeared hot to the touch. We used a thermal imager to scan the room for any source of heat and detected a heat pattern on the floor beneath and in an electrical outlet. We were informed that this was the spot where the transformer for the oxygen device was located. We also checked the adjoining room for any heat signature in the walls. The only heat</p>	F 456		

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F 456	<p>Continued From page 43</p> <p>signature found was at the floor level beneath the electrical outlet in that room. We also removed the baseboard in the room of origin to check for possible fire, but no fire was present. The facility staff was advised that the scene was clear. A member of the fire department remained on scene until the electrical power was restored to the room of origin. " The fire chief added that the staff " acted with safety and care of their patients in mind. "</p> <p>During an interview on 9/8/11 at 11:00 a.m. with the Environmental Consultant, he stated that HVAC units in the patients ' rooms are not used as a heater until in fall of the year. The Environmental Consultant further stated that when the units are turned on for heat, there is a burning smell and this can set off the smoke detectors in the patients ' rooms. He further stated that the HVAC systems are maintained by checking filters monthly, taking the units out of the wall yearly, and doing a complete service and cleaning on the heating and air conditioning system.</p> <p>In an interview on 9/8/11 at 12:00 a.m. with the Administrator, when asked how many O2 concentrators and HVAC units were in the facility and what plans were in place to prevent further occurrences, she stated she did not have a plan in place, because nothing happened.</p>	F 456		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2011
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE OF ELKIN			STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621	
(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
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation on Tuesday, October 4, 2011 between 9:30 AM and 1:00 PM the following was noted: 1) The corridor doors to resident rooms 106, 119B, 127 and 123 did not close latch and seal. 42 CFR 483.70(a)	K 018	<i>Discloser Clause: Preparation and/or execution of the POC does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The POC is prepared solely because it is required.</i> <i>Roller latches will be removed off all doors and replaced with bolts, locks and standard door latch. All roller latches will no longer be used in facility doors. All findings will be taken to PE monthly X 3.</i> <i>The corridor doors to resident rooms 106, 119-B, 127 and 123 will now close, latch, and seal.</i>	11-04-11 10-20-11
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.	K 027	<i>Doors will be checked periodically to insure proper closing, latching and sealing for resident safety. Findings will be taken to PE committee monthly X 3.</i>	

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

TITLE

(X8) DATE

Linda S. [Signature] RN MHA 10-21-11

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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K 027	Continued From page 1 Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027		
K 029 SS=F	This STANDARD is not met as evidenced by: Based on observation on Tuesday, October 4, 2011 between 9:30 AM and 1:00 PM the following was noted: 1) The cross corridor smoke doors located next to resident room 130 did not close smoke tight. 42 CFR 483.70(a) NFFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitlons and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	Astrical strip has been added to the cross corridor smoke doors located next to resident room 130 and now close smoke tight. Astrical strip will remain on smoke doors at all time All findings will be taken to PL committee. Monday X 3.	11-11
	This STANDARD is not met as evidenced by: Based on observation on Tuesday, October 4, 2011 between 9:30 AM and 1:00 PM the following was noted: 1) The oxygen and storage closet located at both		The oxygen and storage closets located at both Ngy station A & B now has a self-closing and latching hardware.	10-21-11

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K 029	Continued From page 2 nurse station A and B did not have a self-closure and latching hardware. 2) The dry storage room in the kitchen did not close, latch and seal. 42 CFR 483.70(a)	K 029	<i>used for storage</i> All doors in hallway with ^{with} self-closure and latching hardware. The dry storage room in the kitchen now has a door with self-closure which latches and seals. All findings will be taken to PT committee X1	11-04-11