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

PRINTED: 11/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345106	A. BUILDING ______ B. WING ______	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME - HICKORY WEST	1125 10 ST BLVD NW HICKORY, NC 28601

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and medical record review, the facility failed to ensure liquids were thickened to nectar consistency for one (1) of three (3) residents on thickened liquids (Resident #156). The findings are: Resident #156 was admitted to the facility with diagnoses of a fall with injuries and dysphagia (impaired swallowing). The facility provided a list of residents assessed to be reliable for interview which included Resident #156. Review of an initial evaluation by the facility Speech Therapist revealed the resident was at risk for choking due to his swallowing disorder and that the resident required nectar thick liquids for safe swallowing. Review of the physician orders revealed an order dated 10/24/11 for a mechanical soft diet and nectar thick liquids. Review of the resident's care plan revealed that fluid volume deficit was addressed as a problem with interventions which included liquids thickened to nectar consistency.	F 309	F309 Provide Care/Services for Highest Well Being **For the resident found to be affected:** On 10/25/2011 Resident #156 diet order including thicken liquids was added to the computerized Kiosk for the C.N.A. and is on the C.N.A. assignment sheet. Nursing Consultant adjusted Kiosk so when orders for thickened liquids are written, the orders will automatically transfer to the C.N.A. flow sheets immediately. The C.N.A. who offered the resident lemonade without thickener was counseled immediately. **For those having the potential to be affected:** For all residents who receive thicken liquids, are on the computerized Kiosk and also on the C.N.A. assignment sheets. Nursing Consultant adjusted Kiosk so when thicken liquid orders are written the order will transfer to the C.N.A. flow sheet immediately. This was completed on 10/25..	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11-18-11

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.

NOV 18 2011
BY: MH

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F 309	Continued From page 1 On 10/25/11 at 10:45 AM Resident #156 was observed lying on his bed in his room. Nursing Assistant (NA) #6, who was pushing the snack cart down the hall from room to room, was observed to ask Resident #156 if he wanted some lemonade He accepted and NA #6 set approximately 120 cc of lemonade on his bedside table and left the room. The lemonade appeared to be unthickened and of normal consistency. When this was pointed out to the resident, he stated that he needed nectar thick liquids and would have to ask the nurse to thicken the lemonade before he could safely drink it. He also stated that occasionally nurses had offered thin liquids to him with his meds and he had told them he needed the liquids nectar thick. On 10/25/11 at 12:15 PM Resident #156 was observed feeding himself lunch with the Speech Therapist monitoring and cueing the resident. She stated his diet had been upgraded from pureed to mechanical soft but he remained on nectar thick liquids. She stated she was trialing the resident today with small sips of thin liquids after each bite of food. The Speech Therapist stated, however, that the resident should only receive nectar thick liquids from other staff members. She stated Resident #156 should not have been given thin consistency lemonade by the NA. She stated she expected staff to check the list of residents who received thickened liquids before passing out thin liquids She stated she expected this list to be available to NAs who were passing out snacks. On 10/25/11 at 12:25 PM NA #6 was interviewed. She stated the lemonade she gave to Resident	F 309	**Measures to ensure compliance:.** The computerized program was updated on 10/25/11 by the Nurse Consultant making the orders for residents who are on thickened liquids visible to the C.N.A.s. On 10/25/11, C.N.A. assignment sheets were updated by M.D.S. nurses. C.N.A.'s and all nursing were notified of the changes by SDC and ADON. All nursing staff were in-serviced by the A.D.O.N and SDC regarding the addition of thickened liquids to the computerized Kiosk and the importance of adhering to orders for thickened liquids. The nurse receiving the order from the physician will be responsible to write new orders when changes are made in the consistency of liquids. Once the order is written the information will transfer immediately to the computerized Kiosk used by the C.N.A and the C.N.A. flow sheet will be updated electronically. Compliance was met by 3:00 pm on 10/25/11. All nursing staff was in serviced on 10/31/11.	

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F 309	Continued From page 2 #156 was not thickened. She stated residents on thickened liquids had coolers to hold thickened liquids in their rooms instead of water pitchers. She also stated there is a list of residents on thickened liquids available to NAs. She stated Resident #156 is fairly new to the facility and she was not aware he was on thickened liquids. She stated she should have checked the list before she gave him thin consistency lemonade On 10/26/11 at 12:35 PM Licensed Nurse #2 was interviewed She stated the fluid status of all residents is on the Medication Administration Record and all nurses were required to check it before administering fluids to a resident. She stated if an NA saw a cooler in a room, they were supposed to inquire of the nurse about the resident's fluid status before serving liquids. She also stated she expected NAs on her hall to ask her about a resident's fluid status anytime they were unsure. She stated NA #6 should have inquired if she were unsure On 10/26/11 at 1:10 PM The Director of Nursing (DON) was interviewed. She stated NAs knew residents were on thickened liquids if they saw a cooler in the room. She stated they could also check the list of residents on thickened liquids or ask the nurse. The DON stated that residents on thickened liquids should be designated on the NA assignment sheet. She stated she expected NA #6 or any NA to use one or more of these methods to determine whether a resident was on thickened liquids before passing out thin liquids.	F 309	<u>To ensure solutions are sustained:</u> The DON/designee will conduct walking rounds 2 times weekly for one month and weekly for 2 months to observe C.N.A.s administering fluids to residents to ensure the appropriate consistency of liquids are being offered to the residents. The MDS nurses will review information visible on the computerized Kiosk for all residents who have orders for thickened liquids no less than quarterly to ensure all information is accurate. The DON/designee will report findings to the to the QA Committee Quarterly with changes made as necessary to ensure solutions are sustained. <u>Corrective action completed:</u> on 10/31/11	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 3 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record and facility policy review, and staff interviews, the facility failed to remove expired and unlabeled medication from	F 431	F431 Drug Records, Label/Store Drugs & Biologicals **For the resident found to have been affected::** The expired and undated medication vial was discarded immediately by licensed nurse on 10/27/11.A new vial was opened dated and placed on cart on 10/27/11 by licensed nurse **For those having the potential to be affected:** On 10/27/11 all med carts were audited by ADON, 2nd shift supervisor and weekend supervisor. No other expired drugs found **Measures to ensure compliance:** The Pharmacy will audit medication carts monthly and remove all expired medications All medication carts will be checked weekly by licensed nurses to ensure expired meds are removed and date opened is noted on medications as applicable. Nursing staff was in- serviced on the importance of dating and disposal of expired drugs on 11/7/11, by DON, ADON, and SDC. In-service entailed watching Insulin administration and checking insulin vials on cart. New hires will be educated on checking insulin vials and dates.	

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F 431	Continued From page 4 the medication cart on one (1) of four (4) medication carts allowing one expired medication to be administered. The findings are: A facility policy related to medication administration and dated 07/26/11 specified check expiration date on package/container prior to drug administration. An observation of the medication cart on the 100 hall on 10/27/11 at 1:57 PM revealed a partially used vial of Insulin with an opened date of 09/08/11 and an expiration date of 10/07/11. Another partially used vial of Insulin that was not designated for any resident contained no opened or expiration dates. Licensed Nurse (LN) #1 was present during this observation. She stated she administered a dose of Insulin from the expired vial today, 10/27/11, at 11:30 AM. LN #1 stated she did not notice the expiration date. She added she should not have administered expired medication. LN #1 stated she did not use the vial that was not designated for any resident. LN #1 continued she should have checked her cart for expired meds when she began her shift. An interview with the Director of Nursing on 10/27/11 at 2:32 PM revealed she expected nurses to note the expiration date of a medication before it was administered.	F 431	<u>~es to make sure solutions tained:</u> DON/designees will audit med carts twice weekly for 90 days for expired or opened liquids without a date opened written on label. Pharmacy consultant will be auditing med passes and checking for expired medications on cart monthly. The DON/designee will report findings to the to the QA Committee with changes made as necessary to ensure solutions are sustained. **Corrective action completed:** on 11/7/11	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 5	F 441		

Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

F441 Infection Control ,prevent spread Linens

For the residents found to have been affected:
The Brief was removed from the bath-room and disposed using proper procedure on 10/24/11.

For those have the potential to be affected:
Resident bathrooms and rooms were audited for any soiled items left uncontained on the floor.
SDC and ADON held in-service with the C.NA.'s on 10/24/11 and discussed soiled briefs are not to be placed on floor and must be bagged and discarded promptly after resident care.

Measures to ensure compliance:
Disposable bags for soiled briefs will placed in door pockets of bathroom in each resident's room by environmental services (EVS).

Additional in-services were held for all nursing staff by SDC and ADON on correct procedures for the discarding of soiled briefs and other potentially infectious materials.

A.D.O.N, 2nd Shift Supervisor and Weekend Supervisor will conduct walking rounds twice weekly for 90 days to check rooms for proper disposal of briefs..

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F 441	Continued From page 6 Based on observations and staff interviews, the facility failed to dispose of soiled briefs in an appropriate manner as observed in two (2) resident bathrooms on one (1) of four (4) halls. The findings are: A facility policy regarding personal care and dated 02/03/11 contained in part soiled disposable briefs should be handled and disposed of so as to prevent contamination of the environment. An observation in the bathroom between Rooms #203 and #204 on 10/24/11 at 3:46 PM revealed an unbagged soiled brief on the floor against the wall in front of the commode. A strong urine odor was noted at this time An interview with Resident #25 on 10/24/11 at 3:46 PM revealed the brief had been on the bathroom floor since after lunch. She stated this was not a usual happening. An observation in the same bathroom on 10/24/11 at 4:01 PM revealed the soiled brief was not present, but the urine odor continued to be noted. An interview with Nursing Assistent (NA) #5 on 10/24/11 at 4:02 PM revealed she had removed the soiled brief from the bathroom floor. She stated she found it on the floor just before this interview. NA #5 stated it was not typical for the residents in the adjoining rooms to leave soiled briefs on the bathroom floor. She added the urine odor came from the brief and it should not have been left on the floor.	F 441	EVS Director or designee will audit 5 Bathrooms twice a week for the next 90 days to ensure bags are in door pockets. Education will be provided to new hires about soiled items and how to properly contain and discard soiled briefs. Corrective action completed on 10/31/2011 **Measures to make sure solutions are sustained:** A.D.O.N, 2nd Shift Supervisor and Weekend Supervisor turn audits into the D.O.N. Immediate training to be provided by ADON/Supervisor for any staff who fail to follow procedures for proper disposal of brief. The D.O.N will report findings during the quarterly CQI/Operations meeting, for the next 90 day. EVS Director or designee will audit 5 bathrooms twice a week for the next 90 days.to ensure bags are in door pockets as required EVS Director will report any deficiencies to the Administrator at the quarterly CQI/Operations meeting for the next 90 days. **Corrective Action completed:** on 10/31/11	

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F 441	Continued From page 7 On 10/26/11 at 2:25 PM an observation from Room #202 into the bathroom that adjoins Room #201 revealed an unbagged soiled brief on the floor between the commode and the wall. Two nursing assistants were observed entering Room #202 to assist a resident. After they left the room, the bathroom door was observed closed and the brief was observed in the same position on the bathroom floor. An interview with NA #3 on 10/26/11 at 11:45 AM revealed the residents in the adjoining rooms were unable to toilet independently. A continued interview with NA #3 on 10/27/11 at 9:10 AM revealed her normal practice was to place soiled briefs in a plastic bag. She added she had not noticed soiled briefs on residents' bathroom floors. An interview with NA #4 on 10/27/11 at 9:16 AM revealed plastic bags are kept in holders mounted on the doors of the bathrooms. She added soiled briefs were supposed to be placed in the plastic bags and not directly on the floor. Observations of bathrooms between the first four (4) rooms on both sides of the 200 hall on 10/27/11 beginning at 9:31 AM revealed clear holders were mounted on the bathroom side of doors. The holders in the bathroom between Rooms #201 and #202 and the bathroom between Rooms #203 and #204 were empty. Plastic bags were observed in the holders on the other bathroom doors. An interview with the Director of Nursing on 10/27/11 at 10:13 AM revealed her expectation	F 441		

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F 441	Continued From page 8 was soiled briefs should not be placed directly on any floor. They should be placed in plastic bags and disposed of promptly.	F 441	F463 Resident Call System-Rooms/ Toilet/Bath	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and medical record review, the facility failed to provide a functioning call system in two (2) of two (2) public toilets available for use by residents The findings are: Resident #93 was admitted to the facility with diagnoses of cardiovascular accident and diabetes. The most recent Minimum Data Set dated 08/16/11 revealed the resident had moderate cognitive impairment and was independent for ambulation in corridors. The facility provided a list of residents assessed to be reliable for interview which included Resident #93. On 10/24/11 at 12:30 PM an observation was made of two unlocked toilets, available for use to the public, both located on the hallways closest to the therapy gym Neither toilet had a call bell system or an emergency alarm system available.	F 463	<u>**For the resident found to have been affected::**</u> For resident #93 the visitor bathroom doors were immediately locked and #93 is unable to open door by 10/27/11. <u>**For those having the potential to be affected:**</u> The nursing home purchased new locks which lock automatically upon closing the bathroom doors and replaced the current locks on the 300/400 bathroom doors. Keys to the bathroom are kept at the nurses station when not in use. Residents will no longer have access to the bathroom on 300 and 400 hall. <u>**Measures to ensure compliance:**</u> The new locks for the 300 and 400 hall bathroom doors will ensure that the doors will remain locked at all times. Keys to the bathrooms are kept at the nurses station for staff and victors. Staff were educated on the new locks on the bathroom doors and where the keys to the bathrooms are to be kept. Completion Date 10/27/11	

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F 463	Continued From page 9 Further observations were made of both toilets on 10/25/11 at 5:00 PM, on 10/26/11 at 6:00 PM, and on 10/27/11 at 12:15 PM. All observations revealed that the toilets remained unlocked and available for use by anyone and that neither toilet had a call bell system or emergency alarm system available. On 10/27/11 at 1:30 PM Resident #93 was interviewed. She stated she had occasionally used the bathrooms across from the therapy gym. She stated she normally used the bathroom in her room, but that if she were ambulating around the facility in her wheelchair, she sometimes had urgency and would use one of the bathrooms near the therapy gym. Resident #93 stated she would stand from her wheelchair, open the toilet door, and ambulate into the toilet. On 10/27/11 at 1:43 PM the Rehab Manager was interviewed. She stated that when a resident needed to use the toilet, a therapist accompanied them back to the bathroom in their room. She stated the toilets across from the therapy gym were meant for use by the public and visitors, not by residents. She also stated, however, that occasionally an ambulatory resident had left the therapy gym and used the public toilets across the hallway. On 10/27/11 at 2:00 PM the Maintenance Director was interviewed. He stated that a functioning call bell system should be in any common area used by residents including showers and toilets. He stated the toilets across from the therapy gym were not equipped with a call bell system. He stated he was aware that residents occasionally used those toilets, though staff redirected them	F 463	**<u>Measures to make sure solutions are sustained:</u>** The Maintenance Director or designee will check visitor bathrooms to ensure the doors are locked and the keys are returned to the Nurses station daily for a period of one month and weekly for two months to assure solutions are sustained. The Maintenance Director/designee will report findings to the to the QA Committee Quarterly with changes made as necessary to ensure solutions are sustained. <u>Corrective action completed</u> on 10/27/11	

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F 463	Continued From page 10 when they observed this. On 10/27/11 at 3:10 PM the Administrator was interviewed. She stated she was not aware that residents used the two toilets across from the therapy gym. She stated she expected any toilet used by a resident should be equipped with a call bell system	F 463		