STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____ DEC 21 2011	12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(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 000	INITIAL COMMENTS This survey began with a complaint investigation on 11/21/2011 through 11/23/2011 and concluded with a recertification survey from 11/28/2011 through 12/01/2011.	F 000	***Submission of the response to the statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required.*** 12/27/11	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the	F 156	**F156 Rights, Rules, Services, Charges** **The Facility will continue to inform the Resident both orally and in writing in a language that the Resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the Facility.** **<u>Criteria 1</u>** **Resident #3 no longer resides at the Facility.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 12-19-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and	F 156	**Criteria 2** **All Residents have the potential to be affected by this deficient practice, therefore, the Director of Nursing has re-assessed all Residents who currently smoke for independence with smoking. At this time there are no Residents who have been assessed to smoke independently without supervision.** **Criteria 3** **For any change in Facility policy, The Administrator will inform the Social Worker and the Social Worker and/or Administrator will notify Residents in writing of said changes. The Social Worker will keep a log of any Facility policy changes.** **Criteria 4** **The Social Worker and/or designee will report any changes of Facility policy at the monthly Quality Assurance (QA) meeting for 3 months or as deemed necessary. The Administrator is responsible for overall compliance.**	

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F 156	Continued From page 2	F 156		

procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to notify 1 of 1 sampled resident (Resident # 3) that was assessed as an independent smoker about the change in facility smoking rules in writing. Findings include:

Resident # 3 was admitted on 04/27/11 with cumulative diagnoses of muscle disuse atrophy, hypertension, anemia, adult failure to thrive and end stage renal disease.

The Smoking Assessment, dated 04/28/11 indicated the resident was considered a

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competent smoker and would be allowed to smoke unsupervised.

Social work progress notes, dated 04/27/11, indicated resident rights were reviewed. On 04/29/11, the social worker (SW) documented Resident #3 was alert and oriented.

A readmission nursing assessment, dated 05/11/11, indicated Resident #3 was alert and oriented to person, place and time.

Physician progress notes, dated 06/03/11, indicated Resident #3 was alert, bright and interactive.

The Quarterly Smoking Review, dated 07/13/11, indicated the resident had to be supervised for smoking. It was indicated the supervision was needed because of policy.

Review of SW notes and nurse's notes did not reveal the resident had been made aware of the change in the facility's smoking policy.

The SW was interviewed on 11/21/11at 1:46 PM. She stated the facility smoking policy in effect when Resident #3 was admitted allowed residents deemed to be safe the ability to smoke unsupervised at will. There were no assigned smoking times. During the summer, the SW stated the policy changed. The SW stated she notified the resident of the policy change verbally, but did not notify Resident # 3 in writing. The SW stated the notification should have been documented in the SW progress notes.

On 11/21/11 at 2:15 PM, the Administrator was

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F 156	Continued From page 4 interviewed. She agreed that residents were notified of the smoking policy change verbally. The Administrator acknowledged no written notices of policy change were given.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility staff used a cold wet washcloth and rubbed ice on the face and neck of 1 of 1 confused residents (resident #41) while the resident slept during lunch in the dining room. Findings include: Resident #41 was admitted to the facility on 5/25/11. Diagnosis included cerebral vascular accident and Alzheimer ' s dementia with agitation and combativeness. MDS assessment dated 8/25/11 revealed the resident was coded as severely impaired for cognitive skills related to daily decision making. She was coded as independent feeding herself and only required meal set up. On 11/28/11 resident #41 was observed from 12:30 pm to 12:43 pm. Resident #41 was seated in her wheelchair at the dinner table asleep. Nursing assistant (NA) #2, NA #3, NA #4 and the Speech Therapist (ST) were in the dining room.	F 241	**F 241 Dignity** **The facility will continue to promote care for Residents in a manner and in an environment that maintains or enhances each Resident's dignity and respect in full recognition of his or her individuality.** **Criteria 1** **NA #2 is no longer employed at the Facility.** **Criteria 2** **All Residents have the potential to be affected by this deficient practice, therefore, the Staff Development Coordinator will re-educate all staff on the importance of maintaining each Resident's dignity and respect in recognition of his or her individuality. In-service will include proper approaches in waking a sleepy Resident as well as how to deal with combativeness and agitation.**	12/27/11

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F 241	Continued From page 5 NA #2 had set up resident #41 ' s tray and tried to awaken her. NA #2 called the residents name, rubbed and gently shook her arms and rubbed a white washcloth over her face and neck. The washcloth was heavy and wet in appearance. Resident #41 continued to sleep. NA #2 then indirectly asked the other NAs in the room for a piece of ice. NA #3 and NA #4 passed lunch trays and fed residents. NA #3 walked over to resident # 41 and rubbed her chest and lifted her chin while she called her name but the resident continued to sleep. NA #3 was not observed with ice. NA #3 walked away. NA #2 held an ice cube in her hand and rubbed it on the residents face and neck then wrapped the ice cube in the washcloth and continued to press the washcloth against resident #41 ' s forehead, cheeks and neck. The resident grimaced but did not awaken. NA #2 also gently tweaked the tip of resident #41 ' s nose several times in a row on two separate occasions which made the resident again grimace but not awaken. NA #2 put food on a utensil and pressed it to resident #41 ' s closed lips while she was asleep two separate times. NA #2 shouted across the dining room to Nurse #4 in the hallway " I even put ice down her shirt and she turned red " . Nurse #4 was in the hall outside the dining room as she prepared for a medication pass and only glanced into dining room; she did not acknowledge NA #2 ' s statement. NA #2 then left the resident at the dining room table asleep. On 11/28/11 at 2:45 pm NA #2 indicated resident #41 was sleepy daily at lunch and she used a cold wet washcloth to help wake her up. NA #2 also indicated she used other methods to wake her up such as gently shaking her and rubbing ice cubes on her face and neck.	F 241	**Criteria 3** **For any Resident who may be affected by this deficient practice, the Nursing staff will continue to make daily rounds in order to monitor Resident/staff activity. Rounds forms will be monitored and maintained in the Director of Nursing's office.** **Criteria 4** **The Director of Nursing and / or designee will report the results of the daily rounds to the monthly Quality Assurance (QA) Committee for 3 months or as deemed necessary. The Administrator is responsible for overall compliance.**	

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On 11/28/11 at 2:45 pm resident #41 was awake in dining room. Resident smiled and said " hi " when spoken to but could not answer questions appropriately when asked and did not have conversation with other staff or residents. NA #2 indicated the resident had eaten lunch.

On 11/30/11 at 12:25 pm resident #41 was asleep in her wheelchair at the dining table. NA #4 called her name and rubbed her upper arms and back. Resident #41 continued to sleep. NA #3 lifted the residents chin and called her name but resident continued to sleep. At 12:35 pm NA #3 left the dining room and returned with a wet wash cloth. Both NA #3 and NA #4 indicated that resident #41 was often sleepy at lunch and to wake her up they call her name, gently shake her and rub her arms to wake her. NA #3 and NA #4 indicated they have never used ice to wake resident #41 that she would eventually wake up and eat on her own. Both NA ' s indicated that 11/28/11 was the first time they have ever seen NA #2 use ice to rub on a resident.

On 11/30/11 at 12:55 pm Nurse #5 indicated she was not aware that resident #41 ' s face had been washed with a cold washcloth nor had she observed resident #41 or any resident have ice rubbed on them.

On 11/30/11 at 1:00 pm the Administrator and the Director of Nursing (DON) both indicated that the use of cold wet washcloths, ice or tweaking a resident ' s nose was unacceptable. The Administrator indicated NA ' s had been inserviced on using warm washcloths to clean resident ' s faces and hands at lunch but never

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F 241	Continued From page 7 cold washcloths. The Administrator told the DON to suspend NA #2 pending investigation of incident. On 11/30/11 at 2:45 pm the Administrator showed documentation that NA #2 had been inserviced three months ago on resident abuse and dignity.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to allow 1 of 1 sampled resident (Resident # 3) that had been assessed as a safe smoker to smoke at will and without supervision. Findings include: Resident # 3 was admitted on 04/27/11 with cumulative diagnoses of muscle disuse atrophy, hypertension, anemia, adult failure to thrive and end stage renal disease. The Social Worker (SW) documented she revived resident rights with Resident # 3 on 04/27/11. The Smoking Assessment, dated 04/28/11 completed by the Director of Nursing (DON) indicated the resident was considered a competent smoker and would be allowed to	F 242	**F 242 Self-Determination – Right to make Choices** **The Facility will continue to ensure the Resident has the right to choose activities, schedules and healthcare consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the Facility; and make choices about aspects of his or her life in the Facility that are significant to the Resident.** **<u>Criteria 1</u>** **Resident #3 no longer resides at the Facility.** **<u>Criteria 2</u>** **All Residents have the potential to be affected by this deficient practice, therefore, the Director of Nursing will review all resident's that currently smoke, re-assess**	12/19/11

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F 242	Continued From page 8 smoke unsupervised. Social work progress notes, dated 04/27/11, indicated resident rights were reviewed. On 04/29/11, the social worker (SW) documented Resident #3 was alert and oriented. A readmission nursing assessment, dated 05/11/11, indicated Resident #3 was alert and oriented to person, place and time. A Rheumatology consultation, dated 06/10/11, indicated Resident #3 had good hand grips and fairly well preserved range of motion. The DON completed a quarterly smoking review on 07/13/11. The DON wrote Resident #3 was to be supervised while smoking adding that supervision was the policy. Physical therapy progress notes, dated 07/18/11 through 07/28/11, indicated Resident # 3 demonstrated good muscle strength. A Quarterly Minimum Data Set (MDS), dated 08/08/11, coded Resident # 3 as cognitively intact. He was able to understand and be understood. Limited assistance was needed with transfer,bed mobility, dressing and personal hygiene. The MDS coded Resident # 3 as independent with locomotion on and off the unit. There was no impairment in upper extremity range of motion coded. On 08/17/11, Physician Progress Notes indicated Resident #3 was alert and oriented to person, place and time. The physician also noted Resident #3's thoughts were goal oriented and	F 242	**the Residents for safety, update the care plan appropriately and notify the resident and/or legal representative of the assessment.** **Criteria 3** **All resident's that smoke will have a smoking assessment completed quarterly and as needed. The resident and/or legal representative will be informed of any changes in the assessment, and the appropriate care plan will be initiated. The Director of Nursing will audit all resident's charts that smoke on a quarterly basis to ensure that any resident that smokes has an updated assessment, and the care plan is appropriate.**	

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F 242	Continued From page 9	F 242	**Criteria 4** **The Director of Nursing will report the results of the audit to the monthly Quality Assurance (QA) Committee for 3 months or as deemed necessary. Recommendations will be made and followed through appropriately. The Administrator is responsible for overall compliance.**	

appropriate.

The SW was interviewed on 11/21/11 at 1:46 PM. She stated the smoking policy was discussed on admission usually within the first 24 hours. When Resident # 3 was admitted in April 2011, he was assessed as a safe smoker. The SW stated this meant he could smoke at will. During the summer, the corporate policy changed. All smokers were now required to be supervised. The SW stated she had observed Resident # 3 smoke and would say he was a safe smoker. Prior to the policy change, Resident # 3 smoked at will.

On 11/21/11 at 2:15 PM, the Administrator was interviewed. She stated the smoking policy changed as a result of the corporate decision to become a smoke free facility. Prior to the change in policy, a smoked deemed safe could smoke at will. The Administrator stated it had been a corporate decision to have designated smoking times.

Nurse # 1 was interviewed on 11/22/11 at 12:30 PM. She stated Resident #3 was a safe smoker. She stated prior to the resident's discharge the facility policy changed. The policy change indicated all smokers were to be supervised and could only smoke at designated times. She added the designated times for smoking was initiated by the DON as a result of corporate policy change. Nurse # 1 stated Resident #3 was capable of lighting and extinguishing his own smoking materials. Prior to the policy change, Resident # 3 smoked at will and was always safe.

The DON was interviewed on 11/23/11 at 12:11

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F 242	Continued From page 10 PM. She acknowledged she had completed the 04/28/11 smoking assessment on Resident #3, adding the information was correct. The DON stated she also completed the 07/13/11 quarterly smoking assessment. She stated she wrote on the quarterly assessment that supervision would be needed because of a corporate policy. The DON stated she was aware that residents deemed safe to smoke had the resident right to independently smoke at will. She added Resident #3 was not declined the right to smoke,but because of corporate policy had to be supervised.	F 242		
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 interviews and record review, the facility failed to assess physical changes for 1 of 7 sampled residents (Resident # 7) whose medical record was reviewed. Findings include: Resident # 7 was admitted to the facility on 10/04/11 with cumulative diagnoses of anemia, chronic kidney disease, diabetes, metabolic encephalopathy, chronic obstructive pulmonary disease (COPD) and end stage renal disease	F 309	**F 309 Provide Care/Services for Highest Well Being** **The Facility will continue to 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.** **<u>Criteria 1</u>** **Resident # 7 no longer resides at the Facility.**	12/27/11

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F 309	Continued From page 11	F 309	**Criteria 2** **All Residents have the potential to be affected by this deficient practice, therefore, all Nursing staff will be in-serviced on the importance of documentation of changes in a Residents condition and appropriate follow-up post-assessment if there is a change. Nursing staff will also be in-serviced on the appropriateness of documentation on the 24 hour report.**	

requiring hemodialysis.

The resident was readmitted to the facility on 10/04/11 after being hospitalized for metabolic encephalopathy. The hospital discharge summary, dated 10/04/11, indicated Resident #7 had no lower extremity edema on discharge.

The Initial Nursing Assessment, dated 10/04/11, documented Resident #7 had decreased breath sounds in his left lower lung field.

An initial plan of care, dated 10/05/11, identified Resident # 7 had a potential for fluid/electrolyte imbalance. Approaches to prevent the imbalance included monitoring for chest pain, shortness of breath, cramps, headache, dizziness, blurred vision, nausea, vomiting and any change in mentation. The care plan also instructed staff to assess skin color, turgor, temperature and moisture of the resident's skin as well as edema since that data was used to evaluate circulation, level of hydration, fluid retention and uremia.

An Admission Minimum Data Set (MDS), dated 10/11/11, indicated Resident #7 was cognitively intact. He was understood and able to understand.

Nurse's notes, dated 10/15/11 at 12:00 PM,. indicated the resident's family visited and reported to staff that Resident # 7 had an upset stomach and felt weak. Review of nurse's notes indicated no assessment was completed to determine the cause of the upset stomach or weakness.

On 10/19/11 at 9:25 AM, the nurse's note

Criteria 3
The Director of Nursing and the Nursing Administration Staff along with the MDS Coordinator will review the 24 hour report at the morning clinical meeting. Medical records will be reviewed for nursing assessment notes, proper documentation and appropriate follow through. Follow up documentation will be noted on the 24 hour follow up log.

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indicated Resident #7 complained about bilateral lower extremity cramping and shortness of breath with walking. The nurse documented an oxygen saturation of 90 % and noted Resident #7 had a change in condition since admission. There was no indication an assessment had been completed or the physician notified about the change.

Physician Progress Notes, dated 10/20/11(24 hours after the occurrence), indicated Resident # 7 was seen for hypoxia when walking. Chest examination revealed decreased breath sounds and a few scattered expiratory wheezes. The physician noted no rales or rubs. The diagnosis was COPD.

Nurse # 2 was interviewed on 11/23/11 at 7:50 AM. Nurse # 2 stated she did not usually work with Resident # 7, but had 8 years of dialysis training. Shortness of breath, she stated, could indicated increased fluid leading to CHF. A resident who experienced shortness of breath should receive an assessment of lung sounds, heart sounds and an oxygen saturation level. The restriction of fluid for most dialysis patients could lead to constipation and gastroparesis. Abdominal assessments to include listening to bowel sounds would be important for any complaints of abdominal pain. All assessments are expected to be documented in the nurse's notes. Nurse # 2 stated if a resident receiving dialysis experienced shortness of breath or a change in oxygen saturation, the physician should be called. She added that dialysis patients are already compromised and have a fluid imbalance. Nurse # 2 stated it took very little time for someone on dialysis to go into fluid overload.

Criteria 4

The Director of Nursing will report any significant findings from the follow up log to the monthly Quality Assurance (QA) Committee for 3 months or as deemed necessary. The Administrator is responsible for overall compliance.

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On 10/23/11 at 9:50 PM, nurse's notes indicated Resident # 7 complained of abdominal pain again. The nurse documented Resident # 3 told her his bowel movement had been hard. The note indicated the nurse gave the resident Miralax (a medication for constipation) and Lortab (a pain medication). There was no evidence an assessment had been completed to determine bowel sounds, tenderness or abdominal distention.

The nurse's note for 10/24/11 at 6:00 PM indicated a call was received from the dialysis unit inquiring about the resident's diet and fluid intake. The dialysis staff member infomed the nurse Resident # 3 had a lot of fluid. There was no assessment to determine lower extremity edema or lung sounds.

On 10/25/11, the nurse's note indicated the results of a chest X-ray revealed Resident # 3 had mild congestive heart failure (CHF). There was no assessment documented to establish a baseline for lower extremity edema or lung sounds.

Nurse's notes for 10/30/11 at 5:20 AM indicated Resident #3's oxygen saturation dropped to 86%. The nurse documented she started oxygen at 2 liters per minute with the oxygen saturation rising to 99%. She noted she would add the drop in saturation to the doctor's notebook. There was no documentation to indicate an assessment had been completed.

A nurse's note for 11/01/11 at 12:45 PM indicated Resident # 7's lets were red, edematous and warm to touch. The nurse did not document an

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assessment to indicate the degree of edema or the presence or absence of adventitious lung sounds.

A nurse's note written on 11/06/11 at 7:30 PM indicated Resident # 3 had complained of feeling dizzy "within the last hour or so." Vital signs were taken, blood sugar tested and oxygen saturation determined to be 99%. The physician was notified. Physician's orders, dated 11/06/11, indicated Resident #7 should be sent to the hospital for evaluation of dizziness and an evaluation of his wounds. A nurse's note, dated 11/06/11 at 7:43 PM, indicated on 911 arrival, Resident #7 had expired.

On 11/22/11 at 11:16 AM, the Director of Nursing (DON) was interviewed. The DON stated when a resident exhibited abdominal pain or complaints of nausea and vomiting, she expected nursing staff to assess the resident. The assessment should include bowel sounds, vital signs, level of pain, and location of pain. The assessment should be documented in the nurse's notes. Any change in condition since admission should be communicated by nurse's note or on the 24 hour report. If the change is acute, the physician should be notified. The DON stated any resident receiving dialysis should be assessed on return from dialysis to include condition of the shunt site, thrill/bruit assessment and any signs and symptoms of infection at the site. If a resident received a diagnoses of CHF, the DON stated she expected the nurses to assess lung sounds, vital signs, edema and check weights if ordered. All assessments should be documented in the nurse's notes. The DON stated if a resident presented with shortness of breath the nurse was

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expected to assess lung sounds, oxygen saturation and color of the skin and document the findings in the nurse's notes. The DON reviewed Resident # 7's nurse's notes and acknowledged assessments had not been completed for the physical symptoms presented. She stated adding Resident # 7 to the physician's book on 10/30/11 at 5:20 AM was not adequate since the resident experienced an acute change. The DON added she was disappointed in the documentation and it was obvious education regarding documentation was needed. The DON stated there were a lot of residents in the facility and only so much time in the day.

Nurse # 1 was interviewed on 11/22/11 at 12:30 PM. Nurse # 1 was the Team Leader for Resident #7's unit. The nurse stated abdominal assessments should be completed for any complaints of abdominal pain or complaints of hard bowel movements. The assessments should include bowel sounds, checking for abdominal distention and tenderness. The facility bowel protocol should be initiated. The nurse stated signs and symptoms of CHF included shortness of breath, crackles in lung fields and edema. She stated the results of the chest X-ray regarding Resident # 3's diagnosis of CHF was either relayed via the 24 hour report or verbally. The nurse stated she was unsure if that information had been relayed to the hall nurse responsible for Resident # 7. Nurse #1 authored the nurse's note from 11/01/11. She stated she was sure she listened to his lungs and had no concern. On 10/19/11, she stated she spoke with the dialysis center about Resident #7 and notified the unit about his leg cramping. The nurse stated she could not remember if she had

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assessed the resident. Nurse #1 explained the change she had noted since admission was the increased tiredness and increased shortness of breath with ambulation.

Nurse # 3 was interviewed on 11/23/11 at 9:00 AM. Nurse # 3 acted as the second shift supervisor for Resident # 7's unit. She stated she received the call from dialysis regarding Resident # 7's intake of food and fluid. She stated she was unable to remember if an assessment to forma baseline was completed. She stated if she had completed an assessment, she would have documented the assessment either in the nurse's notes or on the physician's communication book. Review of the physician's communication book and nurse's notes did not reveal documentation. Nurse #3 stated she was unable to remember if dialysis concerns were communicated to anyone. She added the communication regarding Resident #7 having too much fluid would be important to prevent the resident from going into CHF.

Resident # 7's physician was interviewed on 11/23/11 at 10:30 AM. He stated he would expect any assessment to at least to include vital signs. The physician stated for abdominal pain bowel sounds should be auscultated and pain should be assessed. For shortness of breath, he expected nurses to auscultate lung sounds, check for edema and try to determine some reason for the decline in oxygen saturation. If a resident presented with leg cramps, the physician stated he would suspect an electrolyte imbalance. The physician read the 10/27/11 nurse's note and stated awareness of the pulmonary status was a reasonable expectation. He stated this was

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necessary in order to recognize any other changes. There needed to be a baseline determined for following shifts to compare. After reading the 10/30/11 note, the physician stated the nurse did the correct thing when she started the oxygen,but the physician on call should have been notified. He stated he would have expected documentation of other symptoms such as cough, edema, jugular vein distention, lung sounds and respiratory effort. The physician added he would have made it a point to see the resident if the shortness of breath had been reported. He stated he saw Resident # 7 the Friday before he expired. At that time, the resident was in no acute distress. The physician added there was a need for more critical thinking and better documentation. He stated he felt the nurses were to much into reporting symptoms to him and not enough into assessing for themselves. The physician added Resident # 7 had multiple medical problems and the lack of assessment did not make difference in the resident's outcome.

F 327 SS=D 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record review the facility failed to accurately monitor the fluid intake for 1 of 1 sampled resident (Resident # 7) that had been ordered a fluid restriction. Findings include:

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F 327 Sufficient fluid to Maintain Hydration

12/27/11

The Facility continues to provide each Resident with sufficient fluid intake to maintain proper hydration and health.

Criteria 1
Resident # 7 no longer resides at the Facility.

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F 327	Continued From page 18	F 327	**Criteria 2** **All Residents have the potential to be affected by this deficient practice, therefore, all Nursing staff will be re-educated on following MD orders and the importance of proper documentation with reference to fluid restriction. In-service education will also include the accuracy of documentation. CNA staff will also be in-serviced on the importance of documenting and informing nurse of total fluid intake on their respective shift. Follow up will be addressed at the morning clinical meeting.**	

Resident # 7 was admitted on 10/04/11 with cumulative diagnoses of end stage renal disease requiring hemodialysis three times a week.

Admission orders, dated 10/04/11, included a 1500 cubic centimeter (cc) daily fluid restriction. The Initial Nursing Assessment, dated 10/04/11, identified that Resident # 7 was on a 1500 cc fluid restriction. The assessment also identified the resident with the ability to make his needs known.

Nutrition Progress Notes, dated 10/11/11, identified Resident #7 as receiving a 1500 cc per day fluid restriction.

An Admission Minimum Data Set (MDS), dated 10/11/11, coded Resident # 7 as cognitively intact. The MDS also indicated the resident was independent with eating. Diagnoses included end stage renal disease. Resident # 7 was identified as receiving hemodialysis and a therapeutic diet. He was not identified as having behaviors.

Review of the 10/19/11 Nurse's note indicated Resident # 7 complained of bilateral leg cramping and shortness of breath with walking. Measurement of oxygen saturation indicated a value of 90%. The nurse noted the resident exhibited a change since his admission on 10/04/11.

At the Registered Dietician's (RD) recommendation, an order was written on 10/20/11 to discontinue the fluid restriction and to remove the water pitcher from Resident # 7's bedside.

Criteria 3
For any Resident who may be affected by this deficient practice, The Resident will be noted on the 24 hour report and have a fluid intake monitoring tool initiated. The Nursing Administrative staff will continue to review the daily 24 hour report as well as review of the previous 24 hour MD orders.

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F 327	Continued From page 19 Results of a radiology report on 10/21/11 indicated Resident # 7 had mild congestive heart failure. The Nurse's Note, dated 10/24/11 at 6:00 PM, indicated a dialysis staff member called the facility to question the resident's diet and fluid restriction. The nurse documented the dialysis staff informed her Resident #7 had a "lot of fluid on Saturday." The note did not indicate if the facility nurse conveyed the information to the dialysis staff that Resident # 7's fluid restriction had been discontinued on 10/20/11 or the information the facility did not have an accurate record of his intake prior to the discontinuation of the fluid restriction. Telephone orders, dated 10/25/11, indicated the primary care physician re-initiated the 1500 cc per day fluid restriction. Resident # 7's care plan, dated 10/26/11, indicated a risk for fluid volume excess had been identified as well as the resident's non-compliance at times with the fluid restriction. A goal was established that Resident #7 would be free of edema and his intake and output would be within normal limits. Approaches listed to reach the goal included monitoring and recording the resident's intake and output, report fluid trends and maintain the 1500 cc fluid restriction per physician's orders. The RD documented in the Nutritional Progress notes on 11/03/11 that Resident # 7 was on a 1500 cc per day fluid restriction secondary to a fluid imbalance. The RD also documented she had received a report of resident non-compliance	F 327	**Criteria 4** **The Director of Nursing will report any significant findings from the follow up log to the monthly Quality Assurance (QA) Committee for 3 months or as deemed necessary. The Administrator is responsible for overall compliance.**	

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with the fluid restriction.

On 11/22/11 at 11:16 AM the Director of Nursing (DON) was interviewed. The DON stated fluid restrictions were important to ensure a resident received the proper amount of fluid to prevent congestive heart failure. She added the fluid restriction would be listed on and Intake and Output (I & O) sheet. Each nurse, she stated, was responsible for their shift. Nurses on the 11 to 7 shift were responsible for the daily totals and would be expected to relay the total to the 7 to 3 shift if the fluid restriction was not met. In turn, the 7 to 3 nurse would be expected to notify the physician. The DON stated there was no facility system in place for checking the accuracy of I & O sheets. After the DON reviewed I & O sheets for Resident #7, she stated there was no way to determine his accurate intake since all shifts had not recorded intake. The DON stated an in-service that included expectations on recording I & O had been held on 10/20/11. The in-service addressed specifically residents that were on ordered fluid restrictions. The DON then added she had known Resident # 7's fluid restriction had been restarted. She had checked his I & O sheets, but not on a daily basis. After review of Resident #7's nurse's notes and I & O sheets, she stated the documentation was disappointing and it was obvious education was needed. The DON agreed the 10/20/11 in-service on I & O documentation had not made a difference in nurse's recording accurate intake for Resident #7. The DON stated there were a lot of residents to chart on and only so much time in the day.

Nurse #1 was interviewed on 11/22/11 at 12:30 PM. Nurse # 1 was the 7 to 3 shift team leader for

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F 327	Continued From page 21 Resident #7. The nurse stated Resident # 7 was alert and oriented. She added his family did not bring additional fluids to him. Nurse # 1 stated nurses were expected to monitor and document the intake for a resident on a fluid restriction. The nurse added the accuracy of fluid intake was important because of the potential for fluid overload. The nurse could not identify any person or shift responsible for daily totals of fluid, adding that all shifts/nurses should be involved. Nursing Assistant (NA) # 1 was interviewed on 11/22/11 at 2:44 PM. She had worked with Resident # 7. NA # 1 stated she was not sure if Resident # 7 had been on a fluid restriction or not. Nurse # 2 was interviewed on 11/23/11 at 7:50 AM. Nurse # 2 worked the 11 to 7 shift. The nurse stated she was unsure who was responsible for totaling I & O sheets. After review of Resident # 7's I & O sheet, the nurse stated intake could not be determined since the sheet was not accurate. The nurse stated the staff member involved with Resident # 7 should have brought the intake omissions to the attention of the DON. Nurse # 2 stated she had worked in critical care dialysis for 8 years and knew the importance of accurate documentation of fluid intake to prevent fluid overload leading to congestive heart failure. On 11/23/11 at 8:30 AM, the Registered Nurse (RN) Supervisor was interviewed. She stated her responsibilities included monitoring intake and output. The Supervisor stated this had been done on a daily basis starting 10/31/11. The supervisor reported to the DON on 11/01/11 the I	F 327		

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& O sheets were not being completed. She stated the DON told her to continue to monitor the sheets. On 11/03/11 and 11/04/11, the supervisor stated she gave copies of incomplete and inaccurate I & O sheets to the DON, including the I & O sheet for Resident # 7. At that time, the supervisor stated the DON said an in-service was needed. The supervisor stated she was unsure if an in-service had been held on I & O after 11/04/11. The supervisor stated she took it upon herself to speak to the nurses on the hall and instructed them on completion of I & O sheets. Even after speaking with the hall nurses, the I & O sheets continued to be incomplete and inaccurate. The supervisor stated the DON was aware that Resident # 7 had an extra dialysis treatment because of fluid since she had read it off the 24 hour report.

Nurse # 3, the 3 to 11 team leader, was interviewed on 11/23/11 at 9:00 AM. She had been team leader for Resident # 7's hall. The nurse stated she had been the nurse that received the call from dialysis regarding Resident # 7's diet and fluid restriction. She stated she was unable to recall the conversation and was unsure if she had known Resident # 7's fluid restriction had been discontinued. Nurse # 3 stated accurate I & O was important to make sure the resident received the correct amount of fluid to prevent fluid overload. Nurse # 3 added she could not remember attending any in-service on I & O or any staff member addressing in-complete I & O sheets with her. As a Team Leader, Nurse # 3 stated she did not review I & O sheets for her shift. She stated I & O sheets were located on the front of the Medication Administration Records (MAR), therefore, she assumed the

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nurses were completing the sheets. After review of the I & O sheets for Resident # 7, the nurse stated the sheets were not accurate since there was very little written on the sheets.

The Assistant Director of Nursing (ADON) was interviewed on 11/23/11 at 9:25 AM. She stated the I & O sheet for Resident # 7 should have been placed on the MAR for each nurse to document intake for the assigned shift. The ADON stated the DON was aware the I & O sheets were not being completed accurately since the RN nurse supervisor had given copies of incomplete and inaccurate sheets to her with omissions highlighted. The ADON added that Resident # 7 had specifically been discussed at a morning meeting. Concerns were expressed that Resident # 7 received too much fluid. His non-compliance was also discussed.

Resident # 7's physician was interviewed on 11/23/11 at 10:30 AM. He stated an accurate fluid restriction was important because a resident on dialysis could not get rid of fluid alone. The resident's fluid was managed by dialysis. Too much fluid could potentially cause edema and fluid changes in the lungs.

The DON was interviewed on 11/23/11 at 12:20 PM. She stated the RN supervisor did notify her about incomplete and inaccurate I & O sheet, but denied Resident # 7's sheet had been received. The DON stated Resident #7's fluid restriction was specifically discussed at morning meeting,but she was unsure of what action she took. The DON then stated she spoke with individual nurses about the need to complete I & O sheets accurately, but did not follow up the next

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day to make sure accurate and complete documentation had been completed. The DON could give no reason why she did not follow up on I & O sheet completion.

On 11/23/11 at 2:30 PM, the RD was interviewed. She stated she had recommended discontinuing the fluid restriction and providing specific amounts of fluid from the dietary department to improve the chance Resident # 7 would comply with a limited amount of fluid intake. She stated had she been aware of the resident's shortness of breath on 10/19/11, she probably would not have made that recommendation.

HM

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

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OMB NO. 0938-0391

RECEIVED DEC CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(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 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 12/13/2011 the facility has two areas that do not have sprinkler protection in the dietary department: The areas are the small storage room and the staff bathroom next to the storage room CFR#: 42 CFR 483.70 (a)	K 056	K-056 1.Sprinkler protection will be added to the dietary, small storage room & staff bathroom 2.Staff & residents have the potential to be affected by this practice therefore current practices of monitoring will continue. 3.Maintenance Director will monitor for proper function randomly. 4.Maintenence Director will monitor weekly X 8 weeks and report findings to monthly QI meeting	1-27-12
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K-072 1.ALZ unit nursing staff, housekeeping and rehabilitation staff has been in serviced regarding keeping egress clear & free of wheelchairs.	1-3-12

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

Irene Smith — Interim Administrator — 12-29-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 12/19/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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K 072	Continued From page 1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 12/13/2011 the facility has several wheel chairs in the egress corridor blocking handrails near the required exit as you leave the dining room. CFR#: 42 CFR 483.70 (a)	K 072	2.All residents & staff have potential for harm if unsafe conditions exclse therefore nurses will monitor. 3.Unit nurse (100 W) will monitor for compliance. 4.Results of monitoring will be brought to monthly QI x3	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 12/13/2011 the facility could not verify that the medication refrigerator at the nurses station was on the emergency circuit of the building. CFR#: 42 CFR 483.70 (a)	K 147	K-147 1. Medication refrigeration has been corrected to be on emergency circuit for the building 2. Resident & staff have the potential to be affected by this practice therefore all med refrigerators will be on ER circuit. 3. All refrigerators will be on ER circuit. 4. Maintenence Director will monitor monthly with generator testing and report findings to monthly QI committee x3 months	1-3-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345510	A. BUILDING 02 - BUILDING 02 B. WING _____	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

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K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 12/13/2011 the facility has required exit leading from the west hall past the nurses station that does not have the proper exit directional signage leading to the pack parking lot exit. CFR#: 42 CFR 483.70 (a)	K 047	K-047 Building 2 1. The proper exit directional signage leading to the back parking lot will be installed. 2. All residents & staff have the potential to be affected by this unsafe practice. 3. Maintenance Director will monitor for proper function as part of preventative maintenance rounds. 4. All exit signs will be monitored monthly, findings will be reported to QI meeting monthly x 3	1-3-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Riddle | TITLE: Interim Administrator | (X6) DATE: 12-29-11

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	345510	A. BUILDING 03 - BUILDING 03 B. WING _____	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey on 12/13/2011.	K 000		

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

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