

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

PRINTED: 02/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2012
NAME OF PROVIDER OR SUPPLIER CONOVER NURSING AND REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH STREET SOUTH WEST CONOVER, NC 28613	
(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 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the</p>	F 159	<ol style="list-style-type: none"> 1. Upon notification on 1/19/2012, all interest owed was immediately added to the personal fund accounts for Residents #99 and #20. Further investigation showed that the Business Office Manager checked the correct parameter in the system. However, software failed to add the interest each month. The issue was reported to the software vendor for correction. 2. All resident trust fund accounts were reviewed to ensure interest was paid to each resident as required. 3. The Business Office Manager was re-educated on 1/19/2012 to inspect each resident's account for evidence that interest is added each month. 4. Business Office Manager or her designee will monitor all resident trust fund accounts monthly for at least 3 months to ensure that interest is added to each resident's trust fund account. Data will be reviewed and discussed at quarterly QA meeting. 	2/10/12

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

TITLE

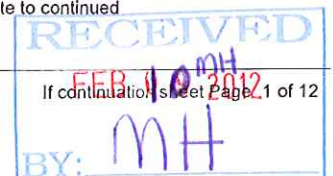
(X6) DATE

[Signature]

Administrator

2/9/12

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 159	<p>Continued From page 1</p> <p>resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to post interest to the personal fund accounts for two (2) of five (5) sampled residents. (Residents #99 and #20).</p> <p>The findings were:</p> <p>1. Resident #99's personal fund account maintained by the facility was reviewed. Resident #99 had \$103.00 in her account the entire year of 2011 with no transactions posted on the account ledger.</p> <p>On 1/19/12 at 11:10 AM, interview with the Business Office Manager (BMO) revealed the computer system maintained by the facility added the interest each month. The BMO stated she should have noticed Resident #99 did not receive interest when the quarterly statements were sent out. The BMO stated she was aware of the requirement for interest to be added for resident fund accounts totaling over \$50.00 each month. During follow up interview on 1/19/12 at 2:24 PM, the BMO stated the parameters in the system were not correctly set to automatically add interest for accounts as required.</p>	F 159		
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F 159	Continued From page 2 2. Resident #20's personal fund account maintained by the facility was reviewed. Resident #20 had \$100.32 in her account the entire year of 2011 with no transactions posted on the account ledger. On 1/19/12 at 11:10 AM, interview with the Business Office Manager (BMO) revealed the computer system maintained by the facility added the interest each month. The BMO stated she should have noticed Resident #20 did not receive interest when the quarterly statements were sent out. The BMO stated she was aware of the requirement for interest to be added for resident fund accounts totaling over \$50.00 each month. During follow up interview on 1/19/12 at 2:24 PM, the BMO stated the parameters in the system were not correctly set to automatically add interest for accounts as required.	F 159			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to provide a Physician ordered psychiatric consult for one (1) of three (3) residents reviewed for psychoactive medications. (Resident #78) The findings are:	F 250			

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F 250	Continued From page 3 Resident #78 was admitted with diagnoses including Alzheimer's Dementia and Depression. A quarterly Minimum Data Set (MDS) dated 11/02/11 revealed Resident #78 was able to make his needs known and was cognitively impaired. During the resident mood interview Resident #78 reported the following problems during the fourteen (14) day look back period: feeling down and depressed nearly every day, feeling tired and having little energy several days, and having trouble concentrating half or more than half of the days. The quarterly MDS noted Resident #78 received antidepressant and antipsychotic medications. Review of Resident #78's medical record revealed a Physician's progress note dated 04/07/11 which indicated the resident's son had been contacted by phone and a psychiatric consult had been ordered. Continued review of the medical record revealed a Physician's order dated 04/07/11 for a psychiatric consult for Depression. The Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 05/05/11 stated Resident #78 had diagnoses including Depression, Bipolar Disorder, and Alzheimer's Dementia. The CAA Summary further noted Resident #78 received antidepressant and antipsychotic medications with no negative side effects observed. Review of a care plan dated 05/05/11 identified Resident #78 as at risk for side effects related to the use of psychotropic medications with interventions including, "Psych consult as	F 250	F250 1. The Social Worker called the responsible party for resident #78 immediately upon notification on 1/19/2012 to notify him that facility failed to provide a Physician ordered psychiatric consult. Responsible Party informed the Social Worker that a psychiatric consult was no longer needed since his father was doing so well compared to April 2011 when initial order was written. The Nurse responsible for communicating psychiatric consult order to Social Worker received disciplinary action for failing to communicate orders in July 2011 and was subsequently terminated in December 2011. 2. The Director of Nursing Services and Assistant Director of Nursing Services reviewed all charts in the facility from April 2011 to assure all Physician ordered psychiatric consults were completed.		

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F 250	Continued From page 4 needed." A social work note dated 11/01/11 stated Resident #78 had short term memory problems and was able to make his needs known. The social worker noted Resident #78 stated he felt depressed due to difficulty concentrating and also because his wife no longer recognized him. During an interview on 01/18/12 at 2:50 PM Resident #78 stated he had been depressed for a "long time" and was sad his wife no longer remembered him. An interview with Licensed Nurse (LN) #3 on 01/19/12 at 10:12 AM revealed when an order for a psychiatric consult was received and noted by a LN a copy of the order was given to the Social Worker (SW) or the Director of Nursing if the SW was not available. An interview was conducted with the SW on 01/19/12 at 11:05 AM. The SW stated LNs gave her a copy of the Physician's order for psychiatric consults and she notified the service of the order. The SW did not recall ever receiving an order for a psychiatric consult for Resident #78. A follow up interview at 3:00 PM revealed the SW had reviewed Resident #78's medical record and concluded the psychiatric consult order was "overlooked."	F 250	3. A system for checking new orders was implemented which requires The Director of Nursing Services or Assistant Director of Nursing Services to review all new orders daily (Monday-Friday) to assure referrals and consults are communicated and completed. The same system requires the 3 rd Shift Supervisor to complete 24hr chart checks daily (Monday-Friday) to assure new orders are communicated and completed. The SW was educated on 1/19/2012 to document the date psychiatric consults are ordered in the resident's record.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329	4. Director of Nursing Services or her designee will monitor 20% of residents to assure compliance with completing physician orders twice monthly for 3 months. Data will be reviewed and discussed at quarterly QA meetings.	2/10/12	

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F 329	<p>Continued From page 5</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to check pulses prior to administering a medication as needed for one (1) of ten (10) sampled residents. Resident #179.</p> <p>The findings were:</p> <p>Resident #179 was admitted to the facility with diagnoses including a hip fracture, cerebral vascular disease and chronic atrial fibrillation.</p> <p>Physician orders for Resident #179 dated 1/9/12 included Lanoxin (Antiarrhythmic agent) 0.25 milligrams to be given by mouth every day. Per</p>	F 329	<p>1. The MAR for Resident #179 was reviewed by Pharmacy Consultant on 1/18/12. MAR was corrected per pharmacy recommendation by the Director of Nursing Services on 1/19/12 to reflect that pulse needed to be taken and recorded prior to Lanoxin/Digoxin administration and to hold dosage for pulse less than 50 per Medical Director (The pulse ceiling was later changed at QA Meeting per Medical Director on 1/26/2012 to hold Lanoxin/Digoxin for pulse less than 55 instead of 50). Medication Aide #1, Licensed Nurse #5, and Licensed Nurse #6, along with all other nursing staff responsible for administering Lanoxin to Resident #179 were counseled regarding checking and recording pulse prior to Lanoxin administration. Licensed Nurse #6 was counseled to ensure that new residents with Lanoxin/Digoxin orders have the pulse documented on the MAR upon admission.</p>		

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F 329	<p>Continued From page 6</p> <p>the Nursing Drug Handbook for 2012, before taking Lanoxin the apical-radial pulse should be taken for one minute and recorded.</p> <p>Review of the Medication Administration Record (MAR) for January 2012 revealed no pulses were recorded from 1/10/12 through 1/19/12. The MAR recorded Lanoxin was administered from 1/10/12 through 1/19/12.</p> <p>On 1/19/12 at 9:30 AM, Licensed Nurse (LN) #5 stated Resident #179's pulse should be taken prior to administering Lanoxin and the pulse should be written on the MAR. She further stated Lanoxin should be held if the resident's pulse is less than 50. LN #5 confirmed there were no pulses documented on the MAR. She stated the Medication Aide (MA) #1 gave the medication this morning. Follow up interview with LN #5 on 1/19/12 at 11:03 AM revealed MA #1 pulled the Lanoxin this morning and LN #5 actually administered the Lanoxin. LN #5 stated she did not question if the pulse was taken, what the pulse was, or check the pulse herself prior to administration of Lanoxin.</p> <p>On 1/19/12 at 9:59 AM, the Medication Aide (MA) #1 stated she had given Resident #179 Lanoxin four times since admission and did not check or confirm that her pulses were taken prior to administering Lanoxin. She further stated this morning an addition was made to the MAR instructing staff to take the pulse prior to Lanoxin administration and hold the Lanoxin if her pulse was less than 50. The MA #1 stated this direction was not on the MAR until this morning. She stated she was not aware of the need to check the resident's pulse prior to the administration of</p>	F 329	<p>2. The MARs for all other residents taking Lanoxin/Digoxin were immediately audited to ensure pulses were being documented and medication administered per policy.</p> <p>3. The DON in-serviced all nursing staff on 1/23/12 to ensure that all residents who are taking Lanoxin/Digoxin should always have a pulse taken prior to administration, and the dose should be held for a pulse less than 55. The admitting nurse will ensure that all residents admitted with Lanoxin/Digoxin orders have the pulse documented on the MAR. The Standing Orders were changed to reflect that pulses are always to be taken prior to Lanoxin administration, and the dose should be held for a pulse less than 55.</p>	

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F 329	Continued From page 7 Lanoxin. On 1/19/12 at 10:09 AM the Director of Nursing (DON) stated she added the need to check pulses on Resident #179's MAR per pharmacy recommendation. She further stated when a resident was admitted, the MARs were hand written by the admitting nurse. The admitting nurse should have written instructions to check the resident's pulse prior to administering Lanoxin on the MAR. On 1/19/12 at 2:17 PM an interview with the pharmacist revealed she spoke to the DON this morning about the need for checking the pulse prior to administrating Lanoxin. She stated this was in response to her 1/18/12 review of Resident #179's record when she noted no pulses were documented prior to the administration of Lanoxin. On 1/20/12 at 9:35 AM LN #6 stated when she admitted Resident #179 she was unaware she should note on the MAR for the resident's pulse to be checked and documented prior to administering Lanoxin.	F 329	4. The Director of Nursing or designee will monitor all MARs with Lanoxin/Digoxin administration twice monthly for 3 months to ensure pulses are being documented prior to administration and the dose would be held for a pulse less than 55 and to ensure all new admissions have pulse documented prior to Lanoxin/Digoxin administration. Data will be reviewed and discussed at quarterly QA meeting.	2/10/12	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an 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 -	F 441			

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F 441	<p>Continued From page 8</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of manufacturer's recommendations, the facility failed to disinfect blood glucose meters in-between residents according to manufacturers instructions for two (2) of two (2) residents observed for medication administration. (Resident #101)</p>	F 441	<ol style="list-style-type: none"> Licensed Nurse #2 and Licensed Nurse #4 were immediately counseled on how to properly clean and disinfect blood glucose meters. All medication carts were immediately checked to ensure that the wipes not meeting requirements were replaced by a 1:10 bleach dilution per manufacturer recommendation. All glucose meters were immediately cleaned according to manufacturer recommendation and disinfected with the 1:10 bleach dilution. All residents requiring blood sugar testing were immediately reviewed to ensure that no communicable diseases were present. The Director of Nursing Services immediately counseled all nursing staff to ensure that all nursing staff understood the proper cleaning and disinfecting procedure for the glucose meters per manufacturer recommendation. 		

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F 441	<p>Continued From page 9</p> <p>Findings include:</p> <p>Manufacturers instructions dated 10/14/10 stated: "recommended cleaning and disinfecting guidelines:</p> <p>Option 1. Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe</p> <p>Option 2. To clean the outside of the blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%). To disinfect the meter, dilute 1ml. (milliliter) of household bleach (5%-6% sodium hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution (final concentration of 0.5% - 0.6% sodium hypochlorite)."</p> <p>1. On 1/19/12 at 3:16 PM Licensed Nurse (LN) #2 was observed using a blood glucose meter to check the blood sugar for Resident #31. LN #2 was observed wiping the blood glucose meter using a alcohol prep pad that was saturated with 70% isopropyl alcohol. The nurse then picked up the blood glucose meter and proceeded to Resident #101's room. The nurse was stopped before entering Resident #101's use to prevent the use of the meter that had not been disinfected. The nurse asked what was wrong. It was explained to the nurse that the blood glucose meter had not been disinfected and she responded: "This is how we do it, is it wrong?" The nurse was asked how she was trained by the facility to disinfect the meter and she stated, "I wiped it with the alcohol prep is that wrong?"</p> <p>On 1/19/12 at 5:19 PM an interview was</p>	F 441	<p>3. A policy and procedure was developed for cleaning and disinfecting glucose meters according to manufacturer recommendation. The Director of Nursing in-serviced all nursing staff 1/19/2012 and 1/20/2012 regarding proper procedure for cleaning and disinfecting glucose meters according to manufacturer recommendation. All nursing staff and Department Heads and Managers return demonstrated the new procedure to the Director of Nursing, ensuring competency in cleaning and disinfecting correctly per manufacturer recommendations. A second facility-wide in-service was conducted on 1/23/2012 and included infection control procedures for properly cleaning and disinfecting glucose meters per manufacturer recommendations. A third facility-wide in-service was conducted on 2/2/2012 to educate staff on the new policy and procedure stating that each</p>		

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(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 441	<p>Continued From page 10</p> <p>conducted with the Director of Nursing (DON). During the interview the DON stated she expected licensed nurses and medication aides to disinfect blood glucose meters after each use with a wipe which contained a diluted bleach solution (5% to 6% sodium hypochlorite solution) per the manufacturer's recommendations. The DON noted she conducted a mandatory in-service in July 2011 which included instruction on how to properly clean and disinfect blood glucose meters.</p> <p>On 1/20/12 at 8:49 AM the DON provided a copy of the in-service material used for the July 2011 in-service along with the sign-in sheets for who attended. A review of the signatures on the sign in sheets revealed LN #2's signature as attending the in-service.</p> <p>2. On 01/19/12 at 11:30 AM Licensed Nurse (LN) #4 was observed preparing to check a resident's blood sugar. LN #4 indicated she disinfected blood glucose meters after each use and named a disinfecting wipe which met the manufacturer's recommendations. After checking the resident's blood sugar LN #4 returned to her medication cart and wiped down the blood glucose meter with a sanitizing wipe which listed the active ingredient as Benzethonium Chloride 0.1%. LN #4 stated she did not have any other blood sugars to check at that time.</p> <p>On 1/19/12 at 5:19 PM an interview was conducted with the Director of Nursing (DON).</p>	F 441	<p>individual diabetic requiring blood sugar monitoring shall have their own glucose meter. All staff were instructed on the procedure for cleaning and disinfecting the glucose meters for individual use according to manufacturer recommendations.</p> <p>4. The Director of Nursing will monitor all residents requiring blood sugar monitoring monthly for three months to ensure that each individual resident has a personal glucose meter for his/her own use. The Director of Nursing will monitor each nurse once monthly to ensure correct return demonstration on the procedure for cleaning and disinfecting blood glucose meters. Data will be reviewed and discussed at quarterly QA meeting.</p>	2/10/12

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

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F 441	<p>Continued From page 11</p> <p>During the interview the DON stated she expected licensed nurses and medication aides to disinfect blood glucose meters after each use with a wipe which contained a diluted bleach solution (5% to 6% sodium hypochlorite solution) per the manufacturer's recommendations. The DON noted she conducted a mandatory in-service in July 2011 which included instruction on how to properly clean and disinfect blood glucose meters.</p> <p>On 1/20/12 at 8:49 AM the DON provided a copy of the in-service material used for the July 2011 in-service regarding recommendations for cleaning and disinfection of blood glucose meters. A review of the in-service sign in sheet revealed LN #4 attended on 07/07/11.</p> <p>During a follow up interview on 01/20/12 at 9:16 AM LN #4 stated she was aware the sanitizing wipe she used to disinfect the blood glucose meter on 01/19/12 at 11:30 AM was not the product she had been instructed to use during in-service training. LN #4 further stated she used the wipe because it was what she had available on the medication cart. The interview further revealed LN #4 should have notified the DON on 01/19/12 when she realized she did not have the necessary supplies to properly sanitize the blood glucose meter.</p>	F 441			