MAY 01 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346445	A. BUILDING ______ B. WING ______	03/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENAIRE	4000 GLENAIRE CIRCLE CARY, NC 27511

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and medical record review the facility failed to update the care plan to reflect the resident being placed on palliative care. This was evident for 1 of 2 residents in the survey sample recieving palliative care. (Resident#23). Findings included: Review of the consultation form from palliative services dated 11/29/10 revealed Resident #23 was placed on palliative care services due to the increase in chronic pain, poor appetite and	F 279	**F 279** **Corrective Action:** Resident # 23's care plan was updated on 3/23/11. Resident began receiving palliative care consultations on 11/29/10. On 3/23/12 the following interventions were added to resident's care plan: palliative care consulting for pain and symptoms management. **Corrective Action for Potentially Affected Residents:** All resident care plans are potentially affected by the alleged deficiency. All current resident's care plans were reviewed and updated: J.S.– interventions added for bleeding risk r/t anticoagulation therapy C.I.– interventions added for risk of hyper/hypoglycemia r/t IDDM W.S.– interventions added for bleeding risk r/t anticoagulation therapy J.C.– interventions added for monitoring of psychoactive medication W.A.– interventions added for monitoring of psychoactive medication R.C.– intervention added for lab monitoring related to medication administration H.H– goal updated for neuropathic pain C.K.– interventions added for monitoring of psychoactive medication M.W.– goals and interventions added for control of IDDM E.C.– interventions added for monitoring of psychoactive medication E.C.– new problem, goal and interventions added for hallucinations	4/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Krynovich	ADMINISTRATOR	4/25/12

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.

JB LX

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

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F 279	Continued From page 1 chronic nausea. She required more assistance with her daily care needs due to the increase in pain, decreased in weight due to poor appetite and chronic nausea. Review of care plans revision dated 8/3/11, 8/4/11, 11/1/11, and 1/31/12 revealed no careplan for pallative care During an interview with the MDS coordinator on 3/22/12 at 1:48 PM revealed the resident had a change in status on 10/13/11 when the physician placed her on palliative care. She had increased pain, nausea and poor appetite. The MDS coordinator reviewed the care plan and indicated there was no update to reflect palliative care. Interview with DON (Director of Nurses) on 3/22/12 at 2:20 PM stated the resident has been on palliative care since 11/29/10. The DON stated her expectation was that when the resident was placed with palliative care services, the care plan should have reflected this information. Continued interview with the DON revealed Resident#23 was receiving palliative care and should have the information written on the care plan. The DON indicated Resident#23 had a decline in ADL (activities of daily living) associated with the disease process, increased pain and chronic nausea. Her expectation was that the care plan should be a picture of the care needs of each resident.	F 279	F.W.– goals and interventions added for Coumadin therapy W.T.– goals and interventions added for Hospice care and control of diabetes W.N.– goals and interventions added for control of diabetes J.A.– goals and interventions added for Coumadin therapy M.G.– goals and interventions added for antidepressant therapy E.M.– goals and interventions added for potential for skin breakdown M.H.– goals and interventions added for diet controlled diabetes M.C.– goals and interventions added for Coumadin therapy C.O.– goals and interventions added for Coumadin therapy M.M.– goals and interventions added for Coumadin therapy M.F.– goals and interventions added for antidepressant therapy **Systemic Changes:** 1. All nurse managers were educated on 4/13/12 regarding proper updating and development of comprehensive care plans. 2. All new resident charts, new orders and care plans are to come to the next clinical meeting to ensure that care plans are being properly updated.	4/19/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	3. The MDS Coordinator will have "on-going" training for the nurse managers to ensure that care plans are comprehensive and accurate	

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F 280	Continued From page 2 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to update a careplan after the resident experienced a fall. This was evident in 1 of 2 residents in the survey sample reviewed for falls. (Resident#19) Resident # 19 was re-admitted to the facility on 11/04/11 from hospital with cumulative diagnoses of Hypertension, Hyperlipidemia, Alzheimer's Disease, Seizure Disorder, Benign Prostatic Hypertrophy, Osteoporosis, Cerebrovascular Accident and Right Stroke. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 02/10/2012 Bims score of 11. ADL's : Resident coded as needing extensive assistance with Bed	F274 ~~F 280~~	**Monitoring:** The Director of Nursing has developed an audit tool to monitor care plan updating The Director of Nursing/ Designee will review ten charts randomly throughout the facility three times per week for two weeks, weekly for one month and then monthly for three months to ensure accuracy of resident care plans and continued compliance. The QA Committee will review the results of the audit tools over the next three months to ensure continued compliance. **F 280** **Corrective Action:** Resident # 19's care plan was updated on 3/22/11. Resident had a fall on 3/18/12. On 3/22/12 the care plan was updated to include: physical therapy for gait stability/strengthening, staff to place bedside table within resident's reach, resident instructed on use of grabber/ reacher and was able to return demonstrate appropriate use. **Corrective Action for Potentially Affected Residents:** All resident's who have had falls are potentially affected by the alleged deficiency. All care plans for resident's with falls in the last three months were reviewed and updated: W.T.– interventions added included staff instructed not to leave resident unattended on toilet, keep chair alarm in locked position so resident cannot disengage alarm S.G.– intervention added was staff to ensure that reacher is within resident's reach	4/19/12

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F 280	Continued From page 3 Mobility, Dressing, Toilet Use Personal Hygiene, and Bathing. Total Dependence for locomotion off unit. Limited assist for transfers. Supervision for walk in room, in corridor, locomotion on unit, and eating. Not steady for balance during transitions and walking. Mobility Devices : Walker and wheelchair. Review of the Nurses notes of 3/19/12 indicated the resident had a fall on 03/18/12 at 8:40 PM. The Nurses note read, " Is on fall charting. Bed alarm and geri mat in place for safety precautions. (Sign for at) 3:43 PM S/p (status post) fall, bruise to rt (right) lateral hip and no swelling noted. (Sign for at) 8:41PM small bruise noted to coccyx area." Review of the facility Incident/Accident Report dated 03/18/12 indicated the resident had an unwitnessed fall in his room when he got up independently to go to the bathroom. Steps taken to prevent recurrence included: "Left door open slightly to hear better this evening. Resident okay. Keep bed in lowest position. Remind resident to call for assistance." The Care Plan dated 02/10/12: read, "Problem: Continued to have areas of physical and cognitive decline since his CVA(Cerebrovascular Accident). Not able to remember to call for staff assistance. Gait remains unreliable. Has unstable episodes. Remains a falls risk. Goal: Not fall next 90 days. Approaches: OT/PT(Occupational Therapy/Physical Therapy) involved for strengthening, gait, and ADL'S (Activities of Daily Living). Staff to assist with all toileting. Do not leave him unattended on commode. SBA (Stand By Assistance) with walker for all ambulation. Low	F 280	M.G.– interventions added included aide instructed not to turn back on resident while resident on toilet, dycum to recliner, U/A sent, resident to nap after lunch V.S.– intervention added was aide and resident both instructed to allow aide to assist resident in changing pad C.G.– intervention added was resident to use shower bench while in shower N.C.– intervention added was staff instructed to use gait belt when transferring resident H.U.– intervention added was resident not to be left unattended in wheelchair when personal sitter not available R.B.– intervention added was resident to have stand by assist when ambulating I.H.– interventions added included chair/ bed alarm, educated resident not to walk backwards, U/A sent M.M.– intervention added was to keep resident in populated areas when up in wheelchair B.M.– intervention added was staff instructed to open resident's door with care to ensure resident not standing behind door when entering M.F.– interventions added included bed alarm, staff to anticipate needs to prevent attempts at unassisted ambulation M.B.– interventions added included chair/ bed alarm, concave mattress to bed	4/19/12

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F 280	Continued From page 4 bed with fall mat in place when in bed. Bed/chair alarms in place. Necklace call bell at all times. Lift chair for room." The Care Plan was not updated to reflect the fall dated 03/18/12 . The resident was observed in the room on 03/22/12 at 11:00 AM with the necklace alarm around his neck, and sleeping in the lounge chair. The Lounge chair was equipped with a pad alarm. The bed was observed in lowest position. A staff interview was conducted on 03/22/12 at 2:00 PM with the MDS Coordinator/RN who indicated, " when there are changes in the resident's status, the Nurse Manager and the Unit Nurse are supposed to update the Care Plan." When asked why the resident's Care Plan had not been updated, the MDS Nurse indicated, "I don't know." A staff interview on 03/22/12 at 3:05 PM with the Nurse Manager #1 indicated, "I'm transitioning into the role, and I know when there are changes we need to change the Care Plan, and it is just a matter of my learning. It just got missed." A staff interview was conducted with the Director of Nurses (DON) on 03/22/12 at 3:45 PM . When asked what her expectations were for updating the Care plan when there has been a fall or any change in the resident's condition, the DON indicated, "I expect the Unit Coordinators to update the Care Plans with changes after falls or any other change or incident, and at least a note of review, with new interventions as appropriate."	F 280	**Systemic Changes:** 1. All nurse managers were educated on 4/13/12 regarding the need for updating interventions on care plans for resident's with falls. 2. All residents who have falls will have their care plans brought to the next clinical meeting to ensure that interventions are updated and accurate. 3. The MDS Coordinator will have "on-going" training for nurse managers to ensure accuracy and timeliness of care plan updating **Monitoring:** The Director of Nursing has developed an audit tool to monitor care plan updating The Director of Nursing/ Designee will review all care plans, for residents who have a fall, weekly for four weeks, then monthly for three months to ensure continued compliance. The QA Committee will review the results of the audit tools over the next three months to ensure continued compliance.	