STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement a fall intervention for one of three sampled residents (Resident #49). The findings are: Resident #49 was admitted with diagnoses including dementia, seizure disorder, and status post hip fracture due to falls. The Care Area Assessment (CAA) Summary for cognitive loss/dementia, completed for the annual Minimum Data Set (MDS) dated 11/23/11, stated Resident #49 had significant cognitive impairment and was at risk for falls. The CAA further stated Resident #49 had experienced falls during the past quarter and safety measures had been implemented. A quarterly MDS dated 08/25/12 revealed Resident #49 had short and long-term memory loss and severely impaired cognitive skills for daily decision making. The quarterly MDS indicated Resident #49 required extensive assistance with bed mobility, transfers, and did not ambulate. The quarterly MDS noted Resident #49 had one fall without injury since the most	F 323	F 323 Address how the corrective action will be accomplished for each resident found to be affected by the deficient practices. On 9/19/2012 Resident #49's bed-pad alarm was immediately connected to the alarm box and ensured it was functioning by the ADON. The CNA's care-guide sheet was immediately updated to match the order for bed-pad alarm by the Unit Secretary and verified by the ADON. Address how corrective action will be accomplished for those residents having potential to be affected by same deficient practice. All residents with orders for alarms have a potential to be affected. On 9/19/2012 all residents with alarms were immediately checked to ensure that the alarms were on and functioning properly by the ADON and DON. The care-guides of those residents with alarms were reviewed by the Unit Secretary to ensure the CNA care-guide matched the current alarm order. The Director of Nursing, Assistant Director of Nursing and Team Leader will in-service the RN's and LPN's to ensure that anytime an order for an alarm is taken off, he/she will verify that the CNA care-guide sheet was updated at that time. The in-service began on September 27, 2012 and will be completed by October 12, 2012. Continued on page 2.....	10/12/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy R. Ford	CEO	4 October 2012

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 323	Continued From page 1 recent assessment. Review of the current care plan for falls, last revised on 04/06/12, stated Resident #49 was at risk for falls due to a history of falls and injuries related to medications, impaired balance, and poor coordination. Interventions included: fall mat at bedside, keep bed in low position, and personal alarm in place to alert staff when resident is attempting to get up unassisted. The care plan was not updated to include the bed pad alarm while in bed ordered by the Physician on 09/04/12. Review of Physician's orders revealed an order dated 09/04/12 for a bed pad alarm to be used when Resident #49 was in bed. Review of Resident #49's fall investigations for the last six months revealed one fall from bed on 09/04/12 at 3:10 PM. The investigation stated staff responded to Resident #49's personal alarm sounding and found him sitting on the fall mat next to his bed. No injuries were noted. The interdisciplinary team met after the fall on 09/04/12 and added a bed pad alarm to be used when Resident #49 was in bed. An observation of Resident #49 on 09/19/12 at 11:00 AM revealed he was resting in bed with his eyes closed. The bed was in the lowest position and a fall mat was noted beside the bed. A personal alarm cord was attached to the back of his shirt and the light on the alarm box indicated it was functioning properly. A subsequent observation on 09/19/12 at 2:50 PM revealed Resident #49 was resting in bed with his eyes closed. The bed was in the lowest position and a	F 323	F 323 continued..... Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. Anytime an order is taken off for an alarm it will be checked by the nurse with the CNA care-guide to ensure it has been updated. This practice will begin on September 19, 2012. The ADON/Team Leader will audit the care-guides and all new alarm orders weekly to ensure the alarm is updated and on the care-guide beginning September 27, 2012. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The findings of the weekly new alarm orders and CNA care-guides audits will be taken to the Quarterly Performance Improvement Committee meeting for the next 2 quarters by the DON/ADON. The next Performance Improvement Committee meeting is set for October 16, 2012.	10/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 323	Continued From page 2	F 323		

fall mat was noted beside the bed. A personal alarm cord was attached to the back of his shirt and the light on the alarm box indicated it was functioning properly.

During an interview on 09/19/12 at 11:10 AM nurse aide (NA) #2 confirmed she was currently assigned Resident #49 and had verified his personal alarm was functioning properly when she put him to bed earlier. NA #2 stated she referred to the NA report sheets for her assigned residents for information including fall interventions. An undated report sheet was reviewed during the interview and noted Resident #49 was to have a personal alarm and a fall mat when in bed. NA #2 was not aware the bed pad alarm had been added as an intervention on 09/04/12.

An interview with the unit secretary (US) on 09/19/12 at 2:50 PM revealed she updated the NA report sheets with any pertinent information when she signed off an order in a resident's medical record. The US reviewed Resident #49's Physician's orders dated 09/04/12 and confirmed she had signed off the order for the bed pad alarm. The US further stated she had missed adding the the bed pad alarm to the NA report sheet on 09/04/12.

On 09/19/12 at 2:55 PM Nurse #1 accompanied this surveyor to Resident #49's room while he rested in bed. Nurse #1 confirmed the bed pad alarm was in place under the mattress but it was not connected to the alarm box. Nurse #1 located the alarm box in the top drawer of Resident #49's bedside table and connected the bed pad alarm to the alarm box.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 323	Continued From page 3 During an interview 09/19/12 at 3:10 PM the Director of Nursing (DON) stated the NA report sheet should have been updated by the US on 09/04/12 to include the Physician's order for Resident #49 to have a bed pad alarm.	F 323	F 498 Address how the corrective action will be accomplished for each resident found to be affected by the deficient practices. Resident # 43 was immediately re-weighed on 9/19/2012 revealing that the resident did not have a weight variance from August 2012 weight. Address how corrective action will be accomplished for those residents having potential to be affected by same deficient practice. All residents have a potential to be affected. All resident's August weights were compared with September weights for variances by the Registered Dietician on September 19, 2012. On 9/19/2012 CNA #1 was re-educated by the DON on weighing residents, re-weighing with 3 pound weight variances, and notifying the nurse when there is a 3 pound or more variance. She was also given a copy of the current weight policy. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. Continued on page 5.....	
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to re-weigh a resident when a significant weight loss was noted for one (1) of two (2) residents. (Resident #43). The findings are: A facility policy concerning resident weights revised 10/06/09 specified re-weigh a resident whenever there was a gain or loss of three (3) or more pounds. A review was conducted of a printed facility document entitled monthly weights 2012. The document specified Resident #43's August weight was 209.8 pounds. Weights were observed hand written in the September column. The weight recorded for Resident #43 in this column was 176.8 pounds noting a 33 pound weight loss.	F 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 498	Continued From page 4 An interview with nurse aide (NA) #1 on 09/18/12 at 2:49 PM revealed she obtained all the monthly weights. She stated she had hand written the 176.8 weight obtained 09/17/12 which was observed in a column adjoining the 209.8 weight. NA #1 stated she did not reweigh the resident and did not notice the 33 pound weight loss. An interview with the Director of Nursing (DON) on 09/18/12 at 3:03 PM revealed she expected an immediate re-weigh if a weight loss or weight gain of three (3) pounds since the last weight. The DON added a nurse should be notified immediately. Continued interview with the DON on 09/19/12 at 4:13 PM revealed Resident #43 was re-weighed and found without a change in weight. The scale obtaining the 176.8 weight was found to be inaccurate.	F 498	F 498 continued..... RN's, LPN's and CNA's are being educated by the DON, ADON and Team Leader on the policy on weighing residents, the different types of scales, how to use each scale, re-weighing with variances, and notification when there is a weight variance. The in-services began on September 26, 2012 and will be completed by October 12, 2012. New Nurses and CNA's will be in-serviced on weighing of residents during their orientation period by their preceptor beginning September 27, 2012.	10/12/12
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	The ADON/Team Leader will audit weights weekly to ensure if there was a 3 pound variance the resident was re-weighed and the Registered Dietician and the Physician were notified. The weekly audits began on September 26, 2012. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The findings of the weekly audits will be taken to the Quarterly Performance Improvement Committee for the next 2 quarters by the DON/ ADON. The next Performance Improvement Meeting is set for October 16, 2012.	10/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 514	Continued From page 5 Based on staff interviews and record reviews, the facility failed to provide dosages for medications on monthly Physician's Plan of Care for two (2) of eleven (11) residents reviewed. (Residents #29 and #30). The findings are: 1. Resident #29 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease. A review of Resident #29's medical record revealed a physician's order dated 07/02/12 for Mucinex two tablets twice a day as needed for cough. The monthly Physician's Plan of Care (PPC) containing medication orders for August 2012 and September 2012 were reviewed. The PPCs contained the Mucinex order written in the same form with no dosage noted. Both PPCs were observed signed by Nurse #2 as completing the audit to ensure accuracy of medication orders for Resident #29. A review of Resident #29's Medication Administration Record (MAR) revealed instructions for Mucinex 600 milligrams (mg) 2 tablets twice a day as needed for cough. An interview with the Registered Pharmacist (RP) on 09/19/12 at 2:45 PM revealed Mucinex was a brand name and came in 600 milligrams (mg) tablets. The RP continued the Mucinex used by the facility pharmacy was a generic brand that comes in 400 mg tablets. She stated Resident #29 obtained her medications from a local out of facility pharmacy and was provided the 600 mg tablets as the resident requested. The RP acknowledged the instructions for Mucinex on the monthly PPCs was not complete because the	F 514	F 514 Address how the corrective action will be accomplished for each resident found to be affected by the deficient practices. The DON received order clarification on Resident # 29 for dosage of Mucinex on September 20, 2012. The DON received order clarification on Resident # 30's Cosopt on Sept 20, 2012. Address how corrective action will be accomplished for those residents having potential to be affected by same deficient practice. All residents have a potential to be affected by the deficient practice. The Pharmacist reviewed all resident monthly orders to ensure there were no medications with dosage omissions. The audits will be completed by October 3, 2012. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The DON, ADON and Team Leader re-educated RN's and LPN's on ensuring that a dosage is obtained for any medication order received and that it is on the Physicians Plan of Care. The in-services began on September 27, 2012 and will be completed by October 12, 2012. Continued on page 7…..	10/03/12 10/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 514	Continued From page 6 dosage was omitted. She stated when she performed monthly medication reviews, she had not noticed the incomplete order. An interview with the Director of Nursing on 09/19/12 at 4:19 PM revealed she expected physician orders contained dosages of medications. An interview with Nurse #2 via phone on 09/20/12 at 9:17 AM revealed she checked the monthly PPC and MARs for accuracy before they were put into use each month. She stated a medication order should include dosage, frequency of administration, and route the medication should be administered. She stated she did not notice the Mucinex did not contain a dosage on the PPC for the months of August and September for Resident #29. 2. Resident #30 was admitted to the facility with diagnoses including glaucoma. A review of Resident #30's medical record revealed monthly Physician's Plan of Care (PPC) for the months of July and August 2012. The PPC contained a physician's order for Cosopt twice a day in left eye only at 12:00 PM and 8:30 PM omitting a dosage to be administered. The order was dated 05/13/10. Continued medical record review revealed a physician's verbal order dated 08/06/12 for Cosopt 1 drop twice a day in the left eye only at 10:00 AM and 8:30 PM. The PPC for the month of September 2012 contained a physician's order dated 08/06/12. The order specified Cosopt twice a day to the left eye only at 10:00 AM and 8:30 PM omitting the dosage. The	F 514	F 514 continued..... The Pharmacist will audit each new medication order along with the Physician's Plan of Care to ensure a dosage has been ordered beginning October 3, 2012. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The findings of the Pharmacist audits will be taken to the Quarterly Performance Improvement Committee meeting for the next 2 quarters by the Pharmacist, DON or ADON. There is a Performance Improvement Committee meeting set for October 16, 2012.	10/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 514	Continued From page 7 PPC monthly audits for July, August, and September were signed by Nurse #2. A review of Resident #30's Medication Administration Record (MAR) contained instructions for Cosopt 1 drop twice a day to the left eye only at 10:00 AM and 8:30 PM. An interview with the Registered Pharmacist (RP) on 09/19/12 at 2:45 PM revealed when she performed monthly medication reviews, she had not noticed the dosage was left off the Cosopt order on the PPCs. She stated the dosage was correct on the corresponding monthly MARs. An interview with the Director of Nursing on 09/19/12 at 4:19 PM revealed she expected PPCs were accurately audited before put into use each month. She added medication orders should contain dosages. An interview with Nurse #2 via phone on 09/20/12 at 9:17 AM revealed she checked the monthly PPC and MAR for accuracy before they were put into use each month. She stated a medication order should include dosage, frequency of administration, and route the medication should be administered. She stated she did not notice the Cosopt on the PPC for the months of July, August and September 2012 did not contain a dosage.	F 514		