STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to obtain physician orders to keep the medication at bedside for self administration of a medication (Ventavis Nebulizer) for 1 of 1 sampled resident. (Resident #113) The findings are: A review of the facility policy on 'Self-Administration of Medications' revised in April 2011 included assessments to be completed by the interdisciplinary team for competence of the resident to self-administer medication and a physician order should be written: 'may keep at bedside' to facilitate self administration. Resident #113 was admitted to the facility on 09/27/12. Resident #113's admission diagnoses included pulmonary hypertension, congestive heart failure and chronic obstructive pulmonary disease. The resident was observed preparing the inhaler and self administering Ventavis inhaler on 10/02/12 at 4:38 PM. Resident #113 was observed again on 10/03/12 at 11:47 AM self administering the medication and the inhaler and other supplies were at the bedside of Resident #113.	F 176	A physician order was immediately obtained on 10/04/12 for Resident #113 to keep the Ventavis 20Mcg at bedside. The nursing staff was immediately educated and verbalized a correct understanding of the policy entitled "Self Administration of Medications". Knowing that all residents are potentially affected by this deficient practice, all nursing staff have been re-educated on this policy. A sign-in sheet has been provided for proof of education with a completion date of 10/26/12. For quality monitoring, the ADON will perform 20 random audits per month. The nursing staff will be asked if any residents are receiving medications that are being kept at the bedside. If any resident(s) are receiving medications at bedside, the medical record will be audited for compliance of having a physician's order to keep the medication at bedside. This data will be shared at monthly staff meetings and to the QCC (Quality Coordinating Council) quarterly. When 100% compliance is not met, education and counseling will be held for responsible staff. If no unreported occurrences are found after 3 months, the audit will go to an annual audit.	10/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Connie Cook RN	DON	11-07-2012

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.

Original Signature 10-26-12 NH

NOV 08 2012
BY:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 176	Continued From page 1 A review of the physician orders dated 09/27/12 included an order for: Ventavis 20 Mcg (microgram)/ml (milliliter). The order included to use Patient's own Medication as this was a non-stocked item of the facility pharmacy and the Ventavis inhaler had to be used 6 times per day. The physician order reviews failed to indicate to leave the medication at the bedside and there were no orders in the medical records specifying 'may keep at bedside.' A review of the Medication Administration Records (MAR's) for the month of September 2012 and October 2012 revealed that Ventavis 20 Mcg was administered 6 times daily per physician orders. An interview was completed with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10/04/12 at 8:55 AM. The interview revealed that all residents approved for self administering medications should have a physician order to keep the medication at bed side and the nurse who admitted the resident was responsible for obtaining the accurate physician orders. The DON was not sure why such an order was not obtained for Resident #113. Nurse #4 who admitted Resident #113 was interviewed on 10/04/12 at 3:19 PM. The interview revealed that Resident #113 had been using Ventavis inhaler for a long time and she had forgotten to obtain the physician order to keep it at bedside.	F 176		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 246	Continued From page 2 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to individualize the environment for 1 of 1 resident with a visual impairment (Resident #184). The findings are: Resident #184 was admitted to the facility on 09/18/12 with diagnoses that included legal blindness. The resident's medical record revealed an admission assessment dated 09/18/12 documented by Nurse #2 that specified the resident had a significant visual impairment. The assessment did not specify the extent of Resident #184's visual impairment or if it was determined if the Resident required assistive devices to accommodate her environment. The initial Minimum Data Set (MDS) dated 09/30/12 specified the resident had no impaired cognition and had moderately impaired ability to see inadequate light (limited vision; not able to see newspaper headlines but could identify objects). Review of Resident #184's care plan dated 10/01/12 specified a problem area due to visual impairment and listed an intervention to place a sign (with permission) on the resident's door stating "Visually impaired." The resident's care	F 246	The DON was notified by the surveyor of the deficient practice on 10/5/12. Resident #184 was discharged on 10/4/12 so no corrective action was able to be taken for this affected resident. Staff education was immediately initiated on how to individualize a resident's needs who are admitted with visual impairments. Knowing that all residents are potentially affected by this deficient practice, all nursing staff have been re-educated on how to individualize resident's needs who are admitted with visual impairments. These needs include interventions and were specified on a sign-in sheet with a completion date of October 26, 2012. By signing the sign-in sheet, the nurse understands that each resident must be assessed upon admission for need of assistive devices, any modifications made for the resident due to their impairment, the offering of any special equipment such as large button telephone, large print menus, large clocks, and raised call bells. Documentation must be present that all of this was offered to the resident. For quality monitoring, the ADON will perform 20 random audits per month of new resident admissions. These audits will include the admission assessment and the following components will be checked for compliance: documentation of assistive devices; offering of those devices to the resident; and any modifications made for the resident due to their impairment. Additionally, the nursing record, care plan and Kardex will be audited to ensure documentation is being made of any modifications, interventions, and accommodations. This data will be shared at monthly staff meetings and quarterly to the QCC for a goal of 100%. If 100% reporting is not met, education and counseling will be held for responsible staff. If no unreported occurrences are found after 3 months, the audit will go to an annual audit.	10/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 246	Continued From page 3	F 246		

plan did not specify any other interventions to accommodate Resident #184's visual impairment.

Observations were made of Resident #184 in her room on 10/02/12 at 10:00 AM. She was also interviewed at this time and reported she had difficulty seeing small objects. She stated she was able to distinguish between items. She added she was unable to read the clock on the wall in her room and had not been offered a different one. She stated it would depend on the size of the numbers and contrasting lights on the clock whether or not she would be able to read what time it was.

On 10/05/12 at 9:15 AM Nurse Aide (NA) #2 was interviewed and reported she had cared for Resident #184. She added that she was aware that the resident was visually impaired and had difficulty with "little things" defined as finding her telephone, reading the room service menu and telling time with the clock in her room. NA #2 stated that the resident would get confused about the time of day it was and would become agitated. The NA was unaware if the resident could have a different clock that was easier to read.

On 10/05/12 at 1:30 PM the Director of Nursing (DON) was interviewed and stated the admission nurse would be responsible for determining if a resident needed adaptive equipment such as a larger dial telephone, large print room service menu or a different size clock. She stated that Resident #184 was visually impaired and unable to use the telephone in her room, read from the room service menu provided or read the clock in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 246	Continued From page 4 her room. The DON stated she thought the resident's vision was limited to identifying shapes and light. The DON stated she would expect staff to make reasonable accommodations for a resident with a visual impairment. On 10/05/12 at 3:00 PM Nurse #2 was interviewed and stated she was trained to determine upon admission a resident's needs and offer adaptive devices if needed. She reported that if a resident was legally blind she would have offered adaptive devices to accommodate the resident such as a large dial telephone and a raised call bell. She stated she would document in the medical record if she had offered Resident #184 adaptive devices. She stated that large dial telephones and clocks were available through the hospital.	F 246		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and document review the facility staff failed to implement a skin care prevention protocol for a resident with skin breakdown in 1 of 1 resident	F 314	After learning of the deficient practice on 10/3/12 the DON met with the nursing staff who immediately placed Resident #193 on the Skin Prevention Breakdown Protocol. The protocol was initiated in the electronic medical record on 10/3/12 and documented on the resident's Kardex. The facility did audit all current residents medical records on 10/3/12 to determine if a Skin Prevention Breakdown Protocol was appropriate. If appropriate, the auditor verified that the protocol had been initiated. If the protocol had not been initiated, the auditor did a one-on-one education with the responsible nurse. The protocol was immediately initiated in the electronic medical record and written on the resident's kardex. Knowing that all residents are potentially affected by this deficient practice, all nursing staff have been re-educated on when to initiate the Skin Prevention Breakdown Protocol. The	10/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 314	Continued From page 5 observed with skin breakdown. (Resident #193). The findings are: Resident #193 was admitted on 09/28/12 with diagnoses including high blood pressure, heart disease and a bowel obstruction. A review of the admission nursing assessment dated 09/28/12 indicated Resident #193 had no impairment in short or long term memory and no impairment in cognition for daily decision making. The nursing assessment also indicated Resident #193 was dependent on staff for activities of daily living. A review of a facility document titled "Adult Admission Assessment" dated 09/28/12 indicated Resident #193 had a Braden score (skin integrity risk score) of 15 and was at risk for skin breakdown. The assessment further indicated Resident #193 had excoriation (raw, irritated skin) on his buttocks. A review of the skin assessment in the "Adult Admission Assessment dated 09/28/12 indicated Resident #193's skin integrity was not intact and there was a potential problem for friction and shearing of his skin. A review of nurse's progress notes dated 09/28/12 at 9:50 PM indicated a skin abnormality of excoriation on Resident #193's buttocks. A review of nurse's progress notes dated 09/29/12 at 7:08 PM indicated excoriation on Resident #193's buttocks.	F 314	Protocol is initiated when a resident's Braden Scale is $\leq$ 18 and / or when the resident has a wound due to pressure. A sign-in sheet was provided for proof of education for all nurses to sign for a completion date of 10/26/12. For quality monitoring, the ADON will perform 20 random audits per month of new resident admissions. The auditor will confirm that a skin prevention protocol has been initiated if the Braden Scale was 18 or less. Additionally, the auditor will confirm that the nurse has documented on the Kardex and individualized the order set to meet the resident's needs if the skin prevention protocol was initiated. This data will be shared at monthly staff meetings and to the QCC quarterly for a goal of 100%.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 314	Continued From page 6	F 314		

A review of nurse's progress notes dated 09/30/12 at 2:02 PM indicated Resident #193 had excoriation on his sacrum.

A review of nurse's progress notes dated 10/01/12 indicated no documentation of skin excoriation on Resident #193's buttocks.

A review of nurse's progress notes dated 10/02/12 indicated no documentation of skin excoriation on Resident #193's buttocks.

A review of a "Consultation/Specialist Note" with an addendum dated 10/04/12 at 3:07 PM indicated the wound care nurse assessed Resident #193's buttocks and noted 2 small areas that were 1.5 centimeters inside the resident's gluteal fold that were red and peeling. She also documented Resident #193 had an open area from the left (L) of the gluteal fold that was 0.5 centimeter long x 3.5 centimeters wide that appeared to be from pressure and classified it as a Stage I pressure ulcer.

During an observation on 10/03/12 at 9:26 AM Nurse Aide (NA) #3 bathed Resident #193. She turned Resident #193 on his (L) side, washed his back and removed his brief. Resident #193 had 2 open red and raw areas of skin next to each other inside the fold of his buttocks and a third open area of red and raw skin at the (L) of the fold of his buttocks.

During an interview on 10/03/12 at 9:55 AM with NA #3 she stated Resident #193 had not been in the facility for very long but she had cared for him since he was admitted. She explained when he was admitted his bottom was red and raw and it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 314	Continued From page 7 did not look any better or worse today but looked the same to her as it did on the day he was admitted. During an interview on 10/03/12 at 10:18 AM Nurse #3 explained it was the usual process for an initial assessment to be completed when a resident was admitted to the facility and if the resident had a Braden Score of 18 or less nursing staff was supposed to initiate a skin care prevention protocol. She further explained the skin care prevention protocol was a specific order set and it gave specific tasks for nurses to complete. Nurse #3 verified no skin care prevention protocol had been initiated. During an interview on 10/04/12 at 11:44 AM the wound care nurse explained the skin care prevention protocols for the skilled nursing facility were the same as those used in the acute care areas of the hospital. The wound care nurse stated it was expected for nurses to initiate the skin care prevention protocols when a resident had a Braden score of 18 or less and verified since Resident #193 had a Braden score of 15 he should have had a skin care prevention protocol initiated on admission. During an interview on 10/04/12 at 3:10 PM the Assistant Director of Nursing verified the skin care prevention protocol was not documented in the facility's computer system. She explained it should have been initiated on 09/28/12 after the admission assessment was completed. During a follow up interview on 10/04/12 at 3:30 PM the wound care nurse explained she assessed Resident #193 and found he had 2	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 314	Continued From page 8 areas of excoriation in the gluteal fold of his buttocks and a stage I pressure ulcer from the (L) of the gluteal fold. She explained she recommended for staff to apply a Mepilex dressing to the stage I pressure ulcer. During an interview on 10/05/12 at 12:56 PM the Director of Nursing stated it was her expectation for a skin care prevention protocol to be initiated when a resident had a Braden score of 18 or less. She further stated the nursing staff should have initiated the skin care prevention protocol for Resident #193 due to the skin excoriation and stage I pressure ulcer that had been identified.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to indentify and implement measures to prevent weight loss for 1of 3 sampled residents at risk for weight loss (Resident #184). The facility staff also failed to obtain an order for a nutritional supplement for a	F 325	After learning of the deficient practice, the DON educated the nursing staff on the facilities current nutrition and missed meals policy. The RD also re-educated the diet office staff on the current policy of reporting to the Dietician any resident who misses two or more meals. Resident #184 was discharged to home on 10/04/12 and the DON learned of the deficient practice on 10/05/12. Additionally, the RD performed an audit on all residents that were in the facility on 10/5/12. All residents meal intakes were evaluated to determine if any were at risk for weight loss. Five residents were determined to be at risk due to an intake of <50 percent, but each resident already had a plan of action in place per the RD. Knowing that all residents are potentially affected by these deficient practices, all nursing staff and diet office staff have been re-educated on the process of correctly reporting when a resident has missed two or more meals. Nursing staff shall report to the team leader and diet office staff shall report to the dietician for a consultation. Nursing staff and dietary services were required to review the	10/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 325	Continued From page 9 resident at nutritional risk in 1 of 2 residents who received supplements. (Resident #193). The findings are: 1. Resident #184 was admitted to the facility on 09/18/12 with diagnoses that included left hip fracture and legal blindness. Review of Resident #184's medical record revealed a Nutrition Assessment dated 09/24/12 performed by the Registered Dietitian (RD) that specified the resident had nutritional risk factors that included advanced age and recent surgery. The assessment also specified the resident had the potential for nutrition related health problems secondary to being underweight. The RD noted the resident's intake was good and made no recommendations for the resident. The initial Minimum Data Set (MDS) dated 09/30/12 specified the resident had no impaired cognition and required limited assistance with eating and weighed 108 pounds. The MDS also specified the resident had not experienced weight loss. The Nutrition Care Area Assessment (CAA) dated 10/01/12 specified, "Pt (patient) is on a regular diet. Intake 50-90% (percent). Offer supplements with meals. See Dietary notes." Resident #184 did not have a nutrition care plan. Further review of Resident #184's medical record revealed her meal intake record that documented the percentage amount of food she ate for breakfast, lunch and dinner. The meal intake record indicated: 09/18/12	F 325	Nutrition and Missed Meals policy. A sign in sheet was required for proof of education for completion date of 10/26/12. Resident #193 was discharged home on 10/05/12 which was the same day the DON and RD were made aware that the supplement had not been ordered for this resident. The DON and RD immediately discussed the importance of ensuring supplements are ordered on any resident who is at risk for a nutritional problem. Knowing that all residents are potentially affected by this deficient practice, the RD will meet with the MDS nurse weekly to discuss each patient's diet and supplement if applicable. The MDS nurse will verify that the supplement has been ordered for these residents. For quality monitoring, the ADON will perform 10 random audits per month on residents and review their medical record. The ADON will ensure proper reporting is occurring to the RD and Team Leader. The ADON will also perform 10 random audits per month to ensure supplements are being ordered by the dietician if a resident has been recommended that a supplement be ordered. This data will be shared at staff meetings each month and to the QCC quarterly. If 100% compliance is met at the end of 3 months, then the audits will go to an annual audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 325	Continued From page 10 Breakfast - 25% (percent) Lunch - 0% Dinner - 50% 09/19/12 Breakfast - 30% Lunch - 60% Dinner - 25% 09/20/12 Breakfast - 0% Lunch - 0% Dinner - 100% 09/21/12 Breakfast - 0% Lunch - 0% Dinner - 0% 09/22/12 Breakfast - 0% Lunch - 0% Dinner - 0% 09/23/12 Breakfast - 50% Lunch - 25% Dinner - 10% On 10/01/12 the resident was weighed. Her weight was recorded to be 94.8 pounds (-13.2 pounds). On 10/01/12 the RD re-assessed Resident #184 and documented the resident's intake varied between 50 - 90% and noted a 13 pounds weight loss. Her recommendations were to monitor the resident and offer a nutritional supplement.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 325	Continued From page 11	F 325		

Resident #184 was observed on 10/01/12 at 2:00 p.m. in her room. She was interviewed and reported she ate mashed potatoes and macaroni with cheese for lunch. She stated that she had a poor appetite.

Resident #184 was observed on 10/03/12 at 9:30 a.m. in her room and she reported she did not eat breakfast.

On 10/04/12 at 9:40 AM Nurse Aide (NA) #1 was interviewed and reported she was trained to document the meal percentage consumed for her assigned residents in their medical records. She added she had been trained how to examine the remaining food to determine how much the resident ate. NA #1 stated that when a resident refused a meal she would notify the nurse. NA #1 reported she was assigned to care for Resident #184. She stated Resident #184 had not eaten breakfast on 10/04/12. She added that the resident usually did not eat well at meals.

On 10/04/12 at 10:00 AM Nurse #1 was interviewed and reported that nurse aides were responsible for reporting when a resident refused a meal. She added that she would then follow-up with the resident to determine the reason for the meal refusal and offer meal substitutions. Nurse #1 also stated she would notify the RD if she felt there was an underlying concern with the resident. She reported she was unaware of any concerns with Resident #184's meal intake.

On 10/04/12 at 2:15 PM the RD was interviewed and reported she performed an initial nutrition assessment on residents to determine if they had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 325	Continued From page 12	F 325		

nutritional concerns. She specified she reviewed residents' laboratory values and meal percentages documented in the medical record to determine if they needed nutritional interventions. She also added that if she noted a resident to be eating less than 50% at most meals then she would make recommendations for a nutritional supplement to provide additional calories and protein. The RD reviewed Resident #184's meal intake record and confirmed the resident ate poorly. She stated she should have made recommendations but failed to do so. She also added she was notified of the resident's weight loss on 10/01/12 but believed the weight to be inaccurate. She confirmed the resident was not re-weighed to determine if the weight was accurate.

On 10/04/12 the resident was weighed. Her weight at this time was 106.7 pounds.

On 10/05/12 at 1:00 PM the Director of Nursing (DON) was interviewed and reported she would expect the RD and nursing staff to monitor a resident's meal intake and identify concerns immediately. She added that every day concerns with residents were discussed in a morning meeting to determine what interventions needed to be in place. She confirmed that a poor appetite would have been discussed. The DON was unaware that Resident #184 had eaten poorly during her time in the facility and added she would have expected additional nutritional interventions to prevent weight loss.

2. Resident #193 was admitted on 09/28/12 with diagnoses including high blood pressure, heart disease and a bowel obstruction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 325	Continued From page 13	F 325		

A review of the admission nursing assessment dated 09/28/12 indicated Resident #193 had no impairment in short or long term memory and no impairment in cognition for daily decision making. The nursing assessment also indicated Resident #193 was dependent on staff with eating and activities of daily living.

A review of a facility kardex dated 09/28/12 indicated Resident #193 was on a 2000 calorie American Dietetic Association (ADA) diet and to offer 700 milliliters of water every 3 hours while awake.

A review of a facility document titled "Adult Admission Assessment" dated 09/28/12 indicated Resident #193 had a Braden score (a skin integrity risk score) of 15 and was at risk for skin breakdown. The assessment further indicated Resident #193 had excoriation (raw, irritated skin) on his buttocks.

A review of an interim care plan titled "Nutritional Status" dated 10/02/12 indicated goals to increase intake to 75 percent and increase a lab value for albumin (a test to measure the amount of this protein in the clear liquid portion of the blood) that was currently at 2.2 (the normal value range of albumin is between 4.0 and 5.4). The interventions indicated to assist with feeding and offer supplements to Resident #193.

During an interview on 10/05/12 at 10:38 AM the Registered Dietician explained she attended the care plan meeting on 10/02/12 and recommended to offer supplements to Resident #193 because he had recent stomach surgery and his albumin was low and he was not eating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 325	Continued From page 14 well. She stated she failed to write the order for the supplements and he did not get them. During an interview on 10/05/12 at 1:00 PM the Director of Nursing explained the usual process for ordering dietary supplements was the dietician entered the order for supplements in the computerized order entry system and it appeared on the Medication Administration Record so the nurses could see the order. She further explained supplements had to go in as an order so dietary would know to send it up on the resident's meal tray and the Nurse Aides documented the amount of supplement the resident drank with the overall meal intake. She stated it was her expectation for supplements to be provided to residents when recommended on the plan of care. She further stated she expected for staff to make sure they accurately documented the resident's intake so the dietician could monitor and make further recommendations as needed.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	The facility was notified of the dirty fans during the summation conference on 10/5/12. The Food Service Director had inspected and maintenance cleaned all fans on 10/4/12. The fan shrouds and blades were removed and cleaned at that time. Other kitchen surfaces were inspected, wiped down and cleaned on 10/4/12. An additional cleaning will be added to the storage rack cleaning list along with monitoring the fans and cleaning them as necessary every two weeks. A food service cleaning list has been developed and the Food Service Director will monitor and initial the form for completeness monthly. If any dust or build-up is noticed during inspection, an additional cleaning will be scheduled immediately.	10/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 371	Continued From page 15 Based on observations, staff interviews and record review the facility failed to have clean equipment in the food production area and failed to ensure staff covered facial hair. The findings are: 1. An initial tour of the facility's kitchen was made on 10/01/12 at 9:40 AM with the Dietary Manager (DM). Staff were observed preparing lunch in the food preparation area. Observations made of the food preparation area revealed a wall-mounted oscillating fan in use positioned directly above the area that pointed at the tray line. During this observation food was observed uncovered ready for use in the lunch meal service. Observations of the wall-mounted fan revealed thick accumulation of gray dust and debris covering the back of the fan and on the front. The DM was interviewed and reported that staff were responsible for cleaning their assigned work areas at the end of every shift. He stated that he made end-of month rounds to monitor the cleanliness of the kitchen and its equipment and provided documentation of his 08/12 and 07/12 end-of month rounds. The DM reported that he had not performed his 09/12 end-of-month round yet. Review of the documents titled, "Cleaning List," dated 08/29/12 did not specify if the wall fan had been cleaned. The DM was interviewed and reported that the Maintenance Department was responsible for cleaning the wall fans once monthly. The Maintenance Department was unable to provide documentation of when the wall fan was last cleaned.	F 371	Additionally, the clear container, storage rack, pot and pan storage rack, cook's storage rack, china storage rack and sprinkler pipes and heads will be monitored and cleaned monthly. Dietary staff have been re-educated on proper cleaning techniques of kitchen equipment and in-serviced on how to correctly identify equipment and items that need cleaning. A sign-in sheet has been provided for proof of education with a completion date of 10/26/12. Any dust or build-up will be reported immediately to the Food Service Supervisor for cleaning. Findings of the quality monitoring will be reported to the staff at monthly staff meetings and quarterly to the QCC. The facility has provided beard nets for staff working in the food production area. All kitchen staff were immediately educated on 10/5/12 of the deficient practice and nets were provided. For quality monitoring, the Food Service Supervisor will inspect daily to ensure facial hair is covered. If any staff is not in compliance, they will immediately be required to don a beard net or cease working in the food production area. The Food Service Supervisor shall use a daily check list to ensure compliance and report to the Dietary Manager. Findings will be reported to the staff at monthly staff meetings and quarterly to the QCC.	10/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(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 371	Continued From page 16 On 10/05/12 at 9:45 AM the Room Service Manager (Assistant Dietary Manager) was interviewed and reported that he had observed the wall-mounted oscillating fan and confirmed it needed to be cleaned. He reported that Maintenance cleaned the fan once monthly but added he and the DM were responsible for monitoring the cleanliness of the equipment daily. He stated that the fans were used daily and prone to get dirty fast and should be cleaned more often than once a month. The Room Service Manager stated it was an oversight that the fans had not been cleaned sooner. 2. An initial tour of the facility's kitchen was made on 10/01/12 with the Dietary Manager (DM). Staff were observed preparing and serving the lunch meal at 10:30 AM. Observations were made of dietary staff member #1 that revealed he had a thick fully grown beard uncovered. During this time the DM was interviewed and stated staff were not expected to cover facial hair. On 10/03/12 at 11:00 AM observations were made of the lunch meal service that revealed dietary staff member #1 served food with his beard uncovered. On 10/05/12 at 9:45 AM the Room Service Manager (Assistant Dietary Manager) was interviewed and reported that dietary staff were not expected to wear hair coverings over facial hair but stated that dietary staff member #1's full beard should be covered because of the amount of hair he had. He added that it was an oversight that staff were not expected to wear facial hair coverings.	F 371		