STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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=G	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, staff interviews, and record review the facility failed to transfer a resident with a mechanical lift (Resident #21), and failed to implement the fall prevention measures of a low bed and floor mats (Resident #7) for two (2) of five (5) sampled residents. The findings are: 1. Resident #21 was most recently readmitted 12/12/12. Diagnoses included dementia and osteoarthritis. Quarterly Minimum Data Set (MDS) dated 09/24/12 assessed Resident #21 with moderately impaired cognition, requiring extensive assistance with bed mobility, transfers, and does not ambulate. On 12/20/12 at 2:25 PM direct care staff were observed transferring Resident #21 from her bed to a recliner chair with a total mechanical lift. Appropriate lift technique was used for safe transfer. Review of care plan entitled activities of daily living dated 11/26/12 noted the resident's non	F 323	Disclaimer: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 323 1. • Resident # 21 has been re-screened by Physical Therapy regarding her transfer status and is currently transferred utilizing the total lift. The Care Guide has been reviewed and updated to ensure accuracy and the staff has been re-educated regarding resident care and utilizing the care guide appropriately. Involved staff have been verbally counseled. • Residents in the facility have been re-screened by Physical Therapy to ensure that appropriate transfer technique is utilized. The Care Guides have been updated appropriately.	

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

TITLE: Administrator

(X6) DATE: 1-10-2013

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.

DHSR NC Black Mountain MRO Received JAN 11 2013 by: PAM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 ambulatory status. Care plan approaches included to ensure a safe environment, and to use a lift for transfers. Review of PT (Physical Therapy) Rehab Screening dated 12/19/11 indicated Resident #21 required a mechanical lift for transfer due to inability to support weight on the lower extremities. Review of PT Rehab Screening dated 12/13/12 identified no change in the resident's baseline mobility status, and indicated that Resident #21 continued to require mechanical lift for transfers. Review of Post Fall Incident report dated 11/15/12 indicated Resident #21 was transferred from the wheelchair to the toilet with two person assistance. Resident #21 twisted her right ankle and was assisted to the floor by staff. The resident was sent out to the emergency department for evaluation. Review of hospital history and physical (H&P) dated 11/16/12 indicated diagnosis of right ankle dislocation and fracture. The H&P summary indicated conservative management with no surgical repair was appropriate due to Resident #21's history of immobility and no report of pain. The resident returned to the facility 11/16/12 with a splint device to the right lower extremity. On 12/19/12 at 5:50 PM an interview was conducted with Nurse Aide (NA) #3. NA #3 stated she assisted Resident #21 to the bathroom on 11/15/12. NA #3 stated Resident #21 was seated in her wheelchair and asked to go to the bathroom. NA #3 stated she referred to the nursing care guide for direction on how to transfer	F 323	• The Care Guides will continue to be reviewed and updated for accuracy. The facility will ensure that Nursing staff will be educated so that they are competent to read and utilize the Care Guide. Designated Management staff will during quality Zone Rounds ensure compliance with the implementation of the Care Guide. The facility will ensure competency through education at the time of hire, bi-annually and as needed. The facility will also ensure accountability for non-compliance. • Designated Management staff will during Quality Zone Rounds (A process which includes Environmental rounds as well as resident and family rounds and interaction) ensure compliance with the implementation of the Care Guide. The facility will ensure competency through education at the time of hire, bi-annually and as needed. The Director of Nursing/Nursing Supervisor will monitor a minimum of 10% of residents each week to ensure that the Care Guide is being utilized and implemented accordingly. Results of this monitoring will be shared with the Administrator on a weekly basis and with the facility QAPI Committee monthly for a period of 90 days at which time frequency of monitoring will be determined by the Committee.	1/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 the resident. NA #3 stated the care guide indicated to transfer Resident #21 with a stand up lift. NA #3 stated she obtained the stand up lift however it would not fit into the bathroom. NA #3 stated she wheeled Resident #21 into the bathroom in her wheelchair and stood her up to assist her onto the toilet. NA #3 stated the resident's legs became weak and her ankle twisted. NA #3 stated she assisted the resident to the floor and notified the nursing staff. On 12/19/12 at 6:23 PM an interview was conducted with NA #4. NA #4 stated she assisted NA #3 to transfer Resident #21 to the bathroom on 11/15/12. NA #4 stated she referred to the nursing care guide and was aware the resident should be transferred with a stand up lift. NA #4 confirmed that she and NA #3 transferred the resident from the wheelchair to the toilet without the use of the mechanical lift. On 12/20/12 at 3:04 PM an interview was conducted with the Physical Therapist who completed the PT Rehab Screening dated 12/13/12. The Physical Therapist stated her assessment indicated Resident #21 was dependent for all functional mobility and required mechanical lift for all transfers. On 12/20/12 at 3:22 PM an interview was conducted with the Director of Nursing (DON). The DON stated she expected staff to transfer Resident #21 as directed on the plan of care and nursing care guide to ensure residents were transferred safely. 2. Resident #7 was admitted on 01/10/11 to the facility with diagnoses which included Alzheimer's Disease and anxiety.	F 323	2. • The falls intervention/prevention equipment for Resident #7 was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 Review of Resident #7's quarterly Minimum Data Set (MDS) dated 10/11/12 revealed she understood and could understand others with intact cognition. Resident # 7 required limited assistance of one person for transfers and walking. Review of Resident #7's care plan dated 10/15/12 revealed Resident #7 required interventions to prevent falls. Interventions included a sensor pad on the bed, a low bed, floor mats, assistance with ambulation and offer assistance to the bathroom during rounds. Review of nursing notes dated 11/6/12 revealed Resident #7 fell without injury at 9:40 PM during an attempt to independently use the bathroom. The intervention of increasing rounds during the night was added to the care plan. Resident #7's bed alarm sounded before the fall. Review of nursing notes dated 12/12/12 revealed Resident #7 fell without injury at 4:50 PM in the room during an attempt to move an object from a chair. Review of Resident #7's nursing care guide updated 12/17/12 revealed Resident #7 required a low bed, floor mats, bed sensor alarm and required limited assistance to the toilet before and after meals. Observation on 12/17/12 at 4:15 PM revealed Resident #7 in bed with a sensor alarm. The bed was not in the lowest position and the top of the mattress was approximately 2 feet from the floor. There were no floor mats.	F 323	immediately implemented and staff have been re-educated regarding the appropriate use of the Care Guide for resident specific information. Involved staff have been verbally counseled. This resident has been re-assessed by the Interdisciplinary Team and no longer requires mats on the floor. Resident #7 prefers not to have her bed in the lowest position and the bed has been placed at a safe height at which the resident's feet can touch the floor. The resident is in agreement with these changes. • A review has been conducted for facility residents to ensure that appropriate falls intervention equipment is in place and available as per Care Guide. • The Care Guides will continue to be reviewed and updated for accuracy. The facility will ensure that Nursing staff will be educated so that they are competent to read and utilize the Care Guide. Designated Management staff will during quality Zone Rounds ensure compliance with the implementation of the Care Guide. Monitoring that appropriate falls intervention equipment is in place has been added to the Hourly Rounding Log for completion by Nurses and CNAs on a daily basis. The facility will ensure competency through education at the time of hire, bi-annually and as needed. The facility will ensure accountability for noncompliance. • The Director of Nursing/Nursing Supervisor will on a weekly basis monitor 10% of residents to ensure that fall prevention methodologies are accurately documented on the Care Guide and in the Medical Record and are correctly implemented. Results of this monitoring will be shared with the Administrator weekly and with the facility QAPI on a monthly basis for a period of 90 days at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 4 Observation on 12/18/12 at 3:26 PM revealed Resident #7 in bed with a sensor alarm. The bed was not in the lowest position and the top of the mattress was approximately 2 feet from the floor. There were no floor mats. Observation on 12/19/12 at 8:41 AM revealed Resident #7 in bed with a sensor alarm. The bed was not in the lowest position and the top of the mattress was approximately 2 feet from the floor. There were no floor mats. Interview on 12/19/12 at 8:45 AM with Resident #7 revealed she required assistance to bathroom and fell in the past. Resident #7 explained she had to call for help but did not always wait for staff ' s assistance. Observation on 12/19/12 at 10:35 AM revealed Resident #7 sleeping in bed. The bed was not in the lowest position and the top of the mattress was approximately 2 feet from the floor. There were no floor mats. Interview with Nurse Aide (NA) #1 on 12/19/12 at 11:10 AM revealed Resident #7 did not require the bed in the lowest position or floor mats. Nurse Aide #1 explained Resident #7 received assistance with transfers and ambulation with a walker. NA #1 reported the bed could be lowered more but Resident #7 did not require this. NA #1 explained he used the care guide for direction in resident care and provided the copy of the care guide for examination. NA #1 did not see the direction for floor mats and a low bed. Observation on 12/19/12 at 11:40 AM revealed	F 323	which tme frequency of monitoring will be determined by the Committee.	1/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 5 Resident #7 seated on the edge of the bed with both feet dangling. Resident #7 activated the call light. At 11:43 AM, the Director of Nursing (DON) responded and at 11:42 AM, Nurse #1 entered the room assisted Resident #7 with a sweater and transfer into a wheelchair. The bed remained at the same height and there were no floor mats. Observation on 12/19/12 at 2:09 PM revealed Resident #7 sleeping in bed. The bed was not in the lowest position and the top of the mattress was approximately 2 feet from the floor. There were no floor mats. Observation on 12/19/12 at 3:40 PM revealed NA #2 entered the room and assisted Resident #7 to the bathroom and back to bed. NA #2 did not lower the bed to the lowest position. NA #2 exited Resident #7's room. Interview with NA #2 on 12/19/12 at 3:55 PM revealed Resident #7's bed should be in the lowest position to the floor. During this interview, NA #2 returned to Resident #7's room and lowered the bed to the lowest position. NA #2 reported Resident #7 did not require floor mats but the bed should have been in the lowest position. Interview with Nurse #1, the 7:00 AM to 7:00 PM charge nurse, on 12/19/12 at 4:00 PM revealed she was not aware of a need for floor mats for Resident #7. Nurse #1 reported Resident #7's bed should always be in the lowest position and did not notice the bed position. Interview with Nurse #2, nursing supervisor, on 12/19/12 at 4:15 PM revealed Resident #7 should	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 6 have floor mats and the bed in the lowest position. A search for floor mats in Resident #7's room was conducted during this interview. There were no floor mats available in Resident's #7's room Interview with the Director of Nursing (DON) on 12/19/12 at 4:35 PM revealed she expected staff to use the care guide for direction in care. The DON explained if the care guide directed a low bed and floor mats, then Resident #7 required a low bed and floor mats.	F 323		
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation of the breakfast, lunch and dinner meals, the facility failed to serve low fat/low cholesterol diets and consistent carbohydrate diets to 3 of 3 sampled residents with physician ordered therapeutic diets (Residents #7, #29 and #49). The findings are: 1. Resident #49 was admitted to the facility with diagnoses which included congestive heart failure, hypertension and atrial fibrillation. Review of monthly physician's orders dated 12/5/12 revealed Resident #49 was to receive a low fat, low cholesterol diet with Coumadin modifications.	F 367	F 367 • Resident #49, Resident #7 and Resident #29 have been provided with the appropriate therapeutic diet. The Dietary Staff members involved have been verbally counseled for not following the proper procedure and have been re-educated regarding the correct procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 367	Continued From page 7 a) Review of the facility's therapeutic spreadsheet for the breakfast meal on 12/19/12 revealed residents who received a low fat low cholesterol diet were to be served egg substitute, fresh fruit cup, whole wheat bagel, yogurt, margarine and jelly. Observation on 12/19/12 at 8:46 AM revealed Resident #49 was served a breakfast meal of the following items: one ham and cheese croissant, potatoes, fruit, cranberry juice and iced tea. Resident #49 was not to receive the ham and cheese croissant and potatoes. b) Review of the facility's therapeutic spreadsheet for the lunch meal on 12/19/12 revealed residents who received a low fat low cholesterol diet were to be served oven fried chicken, penna pasta steamed chicken, dinner roll and baked apple. Observation on 12/19/12 at 12:00 PM revealed Resident #49 received a lunch meal of the following items: one piece of oven baked chicken, approximately one cup of macaroni and cheese, approximately one half cup of collard greens, one cornbread muffin, one slice of apple pie and iced tea. Resident #49 was not to receive macaroni and cheese, collard greens and apple pie. c) Review of the facility's therapeutic spreadsheet for the dinner meal on 12/19/12 revealed residents who received a low fat low cholesterol diet were to be served grilled ribeye steak, baked potato, broccoli, dinner roll and ¾ cup sliced strawberries.	F 367	• The diet orders for residents in the facility have been reviewed by the Registered Dietician to ensure that diets are accurately documented and implemented as ordered. The Catering Associates will plate up the meal based on the menu spreadsheet provided. • The menu selections have been adjusted to reflect therapeutic diet selections for appropriate residents. The actual diet slips have been color coded so that facility staff can easily recognize resident's dietary restrictions. Inservice has been conducted by the Registered Dietician for Dietary and Nursing staff regarding this process change. This inservice has been incorporated into the facility Educational Program at the time of hire, annually and as needed. • The Dietician will monitor the residents on therapeutic diets each week to ensure that they are receiving the appropriate therapeutic diet. Results of this monitoring will be shared with the Administrator weekly and with the facility QAPI on a monthly basis for a period of 90 days at which time frequency of monitoring will be determined by the Committee.	1/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 367	Continued From page 8 Observation on 12/19/12 at 5:20 PM revealed Resident #49 received a supper meal of grilled steak, broccoli with cheese sauce, baked potato, one roll, two butter pats and strawberry shortcake. Resident #49 was not to receive the broccoli with cheese sauce and strawberry shortcake. Interview with Cook #1 on 12/19/12 at 5:44 PM revealed the caterer's associate told him which diet to plate. Cook #1 reported he did not use a therapeutic spreadsheet as a guide for plating. Cook #1 explained the caterer's associate would tell him what he should plate. Interview with the caterer's associate (CA) #1 on 12/19/12 at 5:47 PM revealed she called out the diets and did not need to use the therapeutic diet spreadsheets. CA #1 explained she received training in diets and remembered the dietary requirements. CA #1 reported Resident #49 received the regular meal by mistake. Interview with the Dietary Manager on 12/20/12 at 9:20 AM revealed Resident #49 should not have received the regular diet and the therapeutic diet spreadsheet should have been posted above the steam table for staff guidance. Interview the Registered Dietician (RD) on 12/20/12 at 9:30 AM revealed staff should use the therapeutic diet spreadsheet as a guide for plating diets. 2. Resident #7 was admitted to the facility on 1/10/11 with diagnoses which included coronary atherosclerotic disease and hypertension.	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 367	Continued From page 9 Review of monthly physician's orders dated 12/5/12 revealed Resident #7 was to receive a 4 Gram Sodium, low fat, low cholesterol diet with soft foods. Review of the facility's therapeutic spreadsheet for the dinner meal on 12/19/12 revealed residents who received a low fat low cholesterol diet were to be served grilled ribeye steak, baked potato, broccoli, dinner roll and ¾ cup sliced strawberries. Observation on 12/19/12 at 5:36 PM revealed Resident #7 was served sliced tomato sandwich with mayonnaise, bowl of corn chowder, two packets of saltine crackers and strawberry shortcake. Resident #7 was not to receive the corn chowder and strawberry shortcake. Interview with Cook #1 on 12/19/12 at 5:44 PM revealed the caterer's associate told him which diet to plate. Cook #1 reported he did not use a therapeutic spreadsheet as a guide for plating. Cook #1 explained the caterer's associate would tell him what he should plate. Interview with the caterer's associate (CA) #1 on 12/19/12 at 5:47 PM revealed she called out the diets and did not need to use the therapeutic diet spreadsheets. CA #1 explained she received training in diets and remembered the dietary requirements and what could be substituted. CA #1 reported Resident #7 received the correct meal as a substitute and the sandwich consisted of regular mayonnaise. Interview with the Dietary Manager on 12/20/12 at 9:20 AM revealed the therapeutic diet	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 367	Continued From page 10 spreadsheet should have been posted above the steam table for staff guidance. Interview the Registered Dietician (RD) on 12/20/12 at 9:30 AM revealed Resident #7 should not receive the regular mayonnaise, corn chowder and strawberry shortcake. The RD explained a binder was available for staff guidance with appropriate substitutions. 3. Resident #29 was readmitted to the facility with diagnoses including Alzheimer's disease, pneumonia, and diabetes mellitus. A review of Resident #29's medical record revealed a physician's order dated 11/19/12 for the resident to receive a consistent carbohydrate diet. A significant change Minimum Data Set (MDS) dated 11/26/12 indicated Resident #29 had moderately impaired cognition. A Care Area Assessment written with this MDS specified Resident #29 had long and short term memory loss, poor decision making skills, and poor safety awareness. A care plan dated 11/28/12 specified Resident #29 had diabetes mellitus and was at risk for episodes of high and low blood sugars. The care plan goal indicated sugar levels would remain within normal limits daily with medication and diet management. Care plan interventions included monitoring for signs of high and low blood sugars and monitoring food intake. A review of a facility therapeutic diet spreadsheet revealed the lunch meal for 12/19/12 should	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 367	Continued From page 11 consist of oven fried chicken, penna pasta, steamed spinach, a dinner roll, seasonal fruit cup, and cinnamon applesauce for desert. The lunch meal for a regular diet on that day consisted of oven fried chicken, macaroni and cheese, collard greens, cornbread, and apple pie. An observation of the lunch meal on 12/19/12 at 12:10 PM revealed Resident #29 received one piece of oven fried chicken, macaroni and cheese, collard greens, corn bread and apple pie. Resident #29 was observed eating all of the meal except for the collard greens. An observation at this time of Resident #29's menu card revealed a regular diet menu had been provided to the resident. An interview with Cook #2 and the Dietary Manager on 12/20/12 at 9:06 AM revealed a consistent carbohydrate diet was a diabetic diet. The cook stated she went by what was circled on the menu card and not by the therapeutic diet spreadsheet. The cook added the therapeutic diet spreadsheet was posted on the tray line within view. An interview with the Registered Dietician (RD) on 12/20/12 at 9:30 AM revealed the dietary staff should provide foods on the therapeutic diet spreadsheet to residents that have orders for these diets. The RD confirmed macaroni and cheese was not a substitution for penna pasts and Resident #29 should not have received apple pie for desert.	F 367		