

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/23/2013
NAME OF PROVIDER OR SUPPLIER CLEVELAND PINES NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 N LAFAYETTE ST SHELBY, NC 28150		
(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 000	INITIAL COMMENTS	F 000	Cleveland Pines Nursing Center . Disclaimer preparation and/or execution of this plan of correction does not constitute admissions or agreement by the Cleveland Pines Nursing Center of the truth of the facts alleged or conclusions set forth in the 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157			



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

Charlotte Young

TITLE

Administrator

(X6) DATE

9-17-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to notify the physician of a medication concern for 1 of 5 sampled residents. (Resident #187)</p> <p>The findings included:</p> <p>Resident #187 was admitted to facility 05/30/13 with diagnoses which included subarachnoid hemorrhage, intraventricular hemorrhage, right middle cerebral infarct secondary to vasospasm, history of atrial fibrillation, diabetes, depression and diverticular disease.. Resident #187 had hospitalizations 07/02/13-07/16/13 secondary to obstructive hydrocephalus with shunt placement and 07/18/13-07/22/13 secondary to decreased level of consciousness.</p> <p>Review of the hospital discharge summary on 07/22/13 included the following principal diagnoses:</p> <ol style="list-style-type: none"> 1. Encephalopathy related to combination of Ativan, Klonopin, Ambien and Risperdal. 2. The patient is keenly sensitive to benzodiazepines and should not receive them." 3. Chronic atrial fibrillation with rapid ventricular rate on admission, resolved, now rate controlled with oral agents. <p>Readmission physician orders dated 07/22/13 included notation under "allergies" that Resident #187 was "sensitive to benzodipines".</p> <p>The readmission care plan dated 08/09/13 included the problem areas: -Resident has diagnosis of cerebrovascular</p>	F 157	<p>The facility will assure the physician is notified regarding medication changes and/or concerns.</p> <p>Resident #187 chart was reviewed and no additional physician notification issues were identified.</p> <p>The Director of Nursing provided education to all nurses regarding the facility procedures for notifying the physician of any medication changes or concerns. All new nurses will be educated on this process during orientation.</p>	9/20/13 8/22/13 8/22/13	

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F 157	<p>Continued From page 2</p> <p>accident with recent shunt placement. Resident exhibits confusion, restlessness with falls. Wanders about facility.</p> <p>Approaches to this problem area included, Keep physician informed of changes.</p> <p>-Resident has diagnosis of psychosis and depression and receives medication therapy (anti-psychotic, anti-depressant, anti-anxiety). At risk for potential adverse effects from psychotropic drugs.</p> <p>Approaches to this problem area included, Follow-up with physician as indicated. Keep family and resident informed of medication changes.</p> <p>A nurses note in the medical record of Resident #187 on 07/24/13 at 11:45 PM noted the nurse practitioner was contacted regarding medication that could be given due to issues with agitation. Orders were given and processed. Review of physician orders noted Clonazepam (a benzodiazepine) 1 mg every 8 hours as needed for agitation. A subsequent nurses note on 07/25/13 at 2:30 AM noted, medications given as ordered as well as Clonazepam 1 mg due to increased agitation.</p> <p>Review of the Medication Administration Records (MARs) for July 2013 and August 2013 noted Resident #187 received Clonazepam the following days</p> <p>07/25-two doses 07/27-two doses 07/28-two doses 07/29-two doses 07/31-one dose 08/03-one dose 08/04-one dose</p>	F 157	<p>New physician orders and physician fax concern sheets will be monitored for changes to ensure the physician has been notified of any changes or concerns. The Director of Nursing/designee will utilize a QA tool to perform audits daily for 3 months. Then random audits will be performed for an additional 3 months. Findings will be reviewed monthly by the Administrator/designee.</p> <p>Findings from the QA audits will be reported during the monthly Quality Management Committee meeting for six months. Additional education and monitoring will be initiated for any identified concerns.</p>	9/20/13	9/13/13

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F 157	<p>Continued From page 3</p> <p>Review of the consultant pharmacist drug regimen review in the medical record of Resident #187 noted the hospital discharge sensitivity to benzodiazepines with a note to the attending physician that "Resident has allergy listing of benzodiazepine sensitivity, but was started on Clonazepam as needed for agitation on 07/22". "Should Clonazepam be discontinued?" The physician responded to this request on 08/09/13 with orders to discontinue the Clonazepam.</p> <p>A nurses note in the medical record of Resident #187 on 08/14/13 at 9:30 PM noted, Orders received and processed for Haldol 5 milligrams now and Clonazepam can be given every eight hours, 1 milligram as needed for increased agitation. A subsequent note on 08/14/13 at 10:15 PM noted, Doctor called to make sure it will be okay for him to have Clonazepam just as a precaution because it was stopped because it made him drowsy and the doctor in Charlotte stopped the Clonazepam because he (the doctor) said that the resident was sensitive to it. (Name of on call physician) said to go ahead and give it and have (name of Resident #187's attending physician) follow-up on it on Friday.</p> <p>A physician's order was written on 08/14/13 (Wednesday) for Clonazepam 1 milligram every 8 hours as needed for increased agitation. Review of the MAR for August 2013 noted Resident #187 received Clonazepam the following days: 08/14-one dose 08/15-one dose 08/16-two doses 08/17-one dose 08/18-one dose 08/19-one dose</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>08/20-two doses 08/21-one dose</p> <p>On 08/22/13 at 10:19 AM the nursing secretary (over the unit Resident #187 resided) explained the facility communication system with physicians. The nursing secretary stated nurses filled out a communication form to address any specific resident concerns and placed it in a folder for the physician to address. The nursing secretary stated after the form was addressed by the resident's physician it was placed in an individual folder in the back of the resident's medical record. The nursing secretary looked in the folder for the attending physician of Resident #187 and stated there was nothing in there specific to Resident #187. The nursing secretary stated the attending physician of Resident #187 did weekly visits on Friday. The nursing secretary stated the on call physician that gave orders on 08/14/13 for Resident #187 did not see residents in the facility but answered any specific concerns after hours.</p> <p>Review of this folder in the medical record of Resident #187 noted nothing specific to the Clonazepam on or after 08/14/13.</p> <p>On 08/23/13 at 10:15 AM the attending physician (MD) of Resident #187 stated he was aware of the recent hospitalization of Resident #187 due to decreased mental status and the hospital discharge orders regarding the sensitivity to benzodiazp. The MD stated he recalled the pharmacist recently alerted him that Clonazepam had been ordered by the nurse practitioner for Resident #187 and though he wasn't convinced it was a true sensitivity, he discontinued it because he didn't want to take a chance. The MD stated</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>as long as the prescribing nurse practitioner/physician is aware of a residents sensitivity he is okay if they chose to prescribe the medication. The MD stated he wasn't aware Clonazepam had been reordered for Resident #187 and didn't recall staff asking him about use of the medication. The MD stated although he thought Resident #187 might be able to handle a low dose of Clonazepam he should have been informed as suggested by the on call physician when orders were obtained on 08/14/13. The MD stated he was in the building on 08/16/13 as well as today and a concern form was not included on either date regarding the Clonazepam for Resident #187. The MD stated although he signed the order for the Clonazepam during his visit on 08/16/13 he does not always have the chart in front of him to know all issues regarding the resident. The MD stated the concern form was the system utilized by staff to communicate any specific resident needs that needed to be addressed during his weekly visit.</p> <p>On 08/23/13 at 2:50 PM the facility Director of Nursing (DON) verified the system in place for staff to communicate any specific resident needs with the attending physician was via the concern form. The DON stated these forms are placed in the file for the physician to address during their visit and then the response is filed on each individual residents medical record. The DON reviewed the nurses notes, physician orders and file of concerns in the medical record of Resident #187 and stated she would have expected Nurse #1 to inform the attending physician of the 08/14/13 order for restarting the Clonazepam.</p> <p>On 08/23/13 at 3:00 PM Nurse #1 verified she wrote the nurses note and physician's order for</p>	F 157			

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F 157	Continued From page 6 the Clonazepam on 08/14/13. Nurse #1 recalled it was a very hectic day and that she didn't remember if she wrote a concern form for the attending physician of Resident #187 as directed by the on call physician. Nurse #1 stated she was aware that was the facility practice and normally would have completed the form and placed it in the physicians folder.	F 157			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interviews the facility failed to assess and honor the choice for bathing frequency for 2 of 2 residents reviewed for choices. (Residents #78 and #60) The findings included: 1. Resident #78 was admitted to the facility 02/20/13 with diagnoses which included Parkinson's disease. Resident #78's most recent Quarterly Minimum Data Set (MDS) dated 07/31/13 assessed her as being cognitively intact and needing total assistance of one person with bathing. The MDS revealed there had been no rejection of care by Resident #78.	F 242	The facility will ensure residents have self-determination and the right to make choices. Resident #78 and #60 were re-assessed to determine their choice for bathing/showering frequency. Per the assessment performed the facility will honor the residents' choice for the frequency of bathing/showers.	9/20/13 8/27/13	

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F 242	Continued From page 7 Resident #78's care plan dated 05/21/13 revealed she required assistance with all activities of daily living. On 08/21/13 at 10:50 AM an interview was conducted with Resident #78. She stated she gets two showers per week but would like to have a shower every day. She stated she had mentioned it to the nursing assistants but she continued to only get two showers per week. On 08/22/13 at 2:24 PM an interview was conducted with Nursing Assistant (NA) #2 who reported some days she worked as part of the shower team and other days she worked as a nursing assistant on the halls. NA #2 stated there was a shower schedule set up by the nursing supervisor which was determined by residents' room number. She stated residents get two showers per week. She stated if a resident stated they wanted a shower more than twice per week it was given but it was not on the shower schedule. NA #2 stated the resident would have to request an extra shower. On 08/22/13 at 2:49 PM an interview was conducted with the Nursing Supervisor who made the shower schedules. She stated there was a preprinted shower schedule for all showers that were given. The nursing supervisor stated residents received two showers per week and staff tried to accommodate the resident preferences for a morning or evening shower. She stated if residents wanted more than two showers per week and they are a rehab patient then rehab will work with them so they can shower independently. She went on to explain if a resident was dependent and they wanted more	F 242	All residents were re-assessed to identify their choice for bathing/showering frequency. Identified choices will be documented and honored. All new admissions will have their bathing preferences assessed and documented. All other residents will have their bathing preferences assessed and documented on a quarterly basis and upon request. These assessments will be reviewed monthly by the Administrator/designee. Findings from the resident assessments will be reported during the monthly Quality Management Committee meeting for 6 months. Additional education and monitoring will be initiated for any identified concerns.	9/20/13 9/20/13 9/13/13	

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F 242	<p>Continued From page 8</p> <p>than two showers per week they would try to give the resident an extra shower on Sunday.</p> <p>On 08/22/13 at 4:10 PM an interview was conducted with the Director of Nursing (DON). The DON stated residents' preference for frequency of showers was not assessed when residents were admitted.</p> <p>2. Resident #60 was admitted to the facility 08/16/12 with diagnoses which included Diabetes. An annual Minimum Data Set (MDS) dated 07/16/13 assessed her as being cognitively intact and needing extensive assistance with bathing. The MDS revealed there had been no rejection of care by Resident #60.</p> <p>On 08/20/13 at 1:40 PM an interview was conducted with Resident #60. She stated she received two showers per week and that was not her choice. Resident #60 added she thought it was the rule and that it was the way it was supposed to be. Resident #60 stated she had asked about changing the shower frequency but nobody responded and she did not pursue it further.</p> <p>On 08/22/13 at 2:24 PM an interview was conducted with Nursing Assistant (NA) #2 who reported some days she worked as part of the shower team and other days she worked as a nursing assistant on the halls. NA #2 stated there was a shower schedule set up by the nursing supervisor which was determined by residents' room number. She stated residents get two showers per week. NA #2 stated if a resident indicated they wanted more than two showers per week then staff would give the shower but not include it on the shower schedule. NA #2 stated</p>	F 242			

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F 242	Continued From page 9 the resident would have to request the extra shower. On 08/22/13 at 2:49 PM an interview was conducted with the Nursing Supervisor who made the shower schedules. She stated there was a preprinted shower schedule for all showers that were given. The nursing supervisor stated residents received two showers per week and staff tried to accommodate residents preference for a morning or evening shower. She stated if residents wanted more than two showers per week and they were a rehab patient then rehab would work with them so they can shower independently. She went on to explain if a resident was dependent and they wanted more than two showers per week they would try to give the resident an extra shower on Sundays.	F 242			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	The facility will follow the laws of the State to ensure the resident has the right to participate planning care-revise and treatment or changes in care and treatment.	9/20/13	

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F 280	<p>Continued From page 10</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a care plan for a resident with a stage IV pressure ulcer for 1 of 2 residents reviewed for pressure ulcers. (Resident #11)</p> <p>The findings included:</p> <p>Resident #11 was admitted to the facility on 09/02/09. Resident #11's diagnoses included diabetes, bilateral above the knee amputations and pressure ulcer.</p> <p>The most recent Annual Minimum Data Set (MDS) dated 08/07/13 assessed Resident #11 as having severe cognitive impairment. The MDS assessed Resident #11 as being at risk for pressure ulcers and having one unstageable pressure ulcer which measured 4 centimeters (cm), x 3.5 cm. The MDS indicated the resident had a pressure reducing device for her bed and was receiving pressure ulcer care.</p> <p>The Care Area Assessment (CAA) dated 08/19/13 read, "Resident has developed one unstageable pressure ulcer. Slough most severe tissue type, 4 cm X 3.5 cm on assessment.</p>	F 280	<p>The care plan for resident #11 has been updated.</p> <p>All other care plans for those residents having pressure ulcers have been reviewed and updated, as needed.</p>	<p>8/22/13</p> <p>9/20/13</p>	

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F 280	<p>Continued From page 11</p> <p>Resident is at risk for further skin breakdown. Will proceed to care plan with pressure ulcers. Nursing to complete skin audits per facility policy, Wound care nurse to measure and document weekly and observe for a need to change orders."</p> <p>Review of Resident #11's care plan dated 05/21/13 revealed she was at risk for pressure ulcers due to decreased mobility, incontinence, and bilateral above the knee amputation. The goal was for Resident #11 to remain free of skin breakdown. Interventions included were to reposition as needed, to provide incontinent care as needed, to complete skin audits per facility policy, and report changes in skin to the nurse. The care plan had not been updated to reflect Resident #11's actual pressure ulcer.</p> <p>Review of Wound Progress record revealed Resident #11's pressure ulcer began on 07/05/13 as a stage I measuring 2 cm x 2 cm. On 07/25/13 the wound was unstageable and measured 3 cm x 3cm. On 08/06/13 the wound was unstageable and measured 4 cm x 3.5 cm. On 08/22/13 the wound was a stage IV with bone showing and measured 3.5 cm x 2 cm.</p> <p>On 08/23/13 an interview was conducted with MDS Nurse #1. She stated it was her job to update care plans. She stated they used the copies of physician orders received from morning stand up meetings to determine if they needed to add or take anything off the care plan. MDS Nurse #1 stated these changes would be hand written on the care plans located on the halls. She stated with pressure ulcers sometimes there was a delay in getting the pink copy of the physician orders or the orders would not be specific regarding what was being treated which resulted</p>	F 280	<p>Administrator educated the MDS nurses on the importance of updating care plans that reflect the current state of those residents with pressure ulcers.</p> <p>RN/UB Auditor/designee will monitor care plans for those residents having pressure ulcers to assure they have been updated to reflect the current state of the wounds every 2 weeks for 3 months then monthly for 3 months. Corrections will be made as identified. All new residents with pressure ulcers will be included in the audit.</p> <p>Findings will be reviewed by the Administrator/designee monthly for 6 months.</p> <p>Findings from the QA audits will be reported during the monthly Quality Management Committee meeting for 6 months. Additional education and monitoring will be initiated for any identified concerns.</p>	<p>8/30/13</p> <p>9/20/13</p> <p>9/20/13</p> <p>9/13/13</p>	

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F 280	Continued From page 12 in the care plan not getting updated. She went on to say pressure ulcers were talked about in morning standup meeting. MDS Nurse #1 stated she made changes to Resident #11's care plan on 08/21/13 but the changes were only in the computer and not out on the care plan located on the floor for staff to utilize. She stated the care plan should have been updated when the wound was discovered. An interview was conducted on 08/23/13 with the Director on Nursing (DON). The DON stated it was her expectation for the care plan to be updated to reflect the residents' current state and condition. She further stated the care plan needed to be accurate for staff members who used them.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to report and document a skin tear for 1 of 3 residents reviewed for non pressure related skin conditions. (Resident #17) The findings include:	F 309	The facility will provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Appropriate documentation and reporting was initiated and completed for Resident #17.	9/20/13 8/22/13	

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F 309	<p>Continued From page 13</p> <p>A facility policy entitled "Alteration in skin integrity-inspection/assessment" with a revised date of 04/10 indicated under procedure: to document assessment findings, communication, intervention and education.</p> <p>Resident #17 was admitted on 11/10/08 with diagnosis of peripheral vascular disease and hypertension. A quarterly minimum data set dated 07/16/13 indicated Resident #17's cognition was impaired and required extensive to total assist with activities of daily living.</p> <p>A plan of care dated 07/30/13 indicated Resident #17 with fragile skin and with the potential for skin impairment. Interventions included: documenting and reporting all skin impairment and reporting deterioration of skin as well as the use of geri-sleeves as tolerated for skin tear prevention.</p> <p>Observation of Resident #17 on 08/21/13 at 8:58 AM revealed the Resident was up in the wheelchair with geri-sleeves to bilateral arms and Steri-Strips to the back of her right hand.</p> <p>Observation of Resident #17 on 08/22/13 at 2:15 PM revealed 4-5 Steri-Strips to the back of her right hand with dried blood around the area and skin tear length difficult to approximate.</p> <p>Review of the Nurse Aide (NA) skin assessment report for the months of July and August revealed no mention of a skin tear to the right hand.</p> <p>Review of the nurse's skin assessment report for the months of July and August revealed no mention of a skin tear to the right hand.</p> <p>A weekly status collection form dated 08/12/13</p>	F 309	<p>All other residents with skin tears were evaluated to assure appropriate reporting, documentation and treatment was initiated per facility policy.</p> <p>Director of Nursing & the Staff Development Coordinator provided re-education to all clinical staff and therapy staff on the facility policies and procedures for documenting and reporting non-pressure related skin conditions.</p> <p>Director of Nursing/Designee will monitor incident reports, 24 hour nursing report, physicians orders and, skin assessments in care tracker for compliance daily for 1 month; then weekly for 2 months; thereafter randomly for 3 months. Variances will be corrected as identified</p> <p>Findings from the QA audits will be reported during the monthly Quality Management Committee meeting for six months. Additional education and monitoring will be initiated for any identified concerns.</p>	<p>9/20/13</p> <p>8/21/13</p> <p>9/20/13</p> <p>9/13/16</p>	

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F 309	<p>Continued From page 14</p> <p>under skin condition indicated fragile skin, coumadin therapy with bruise checked. Skin tear/cut were not checked.</p> <p>A weekly status collection form dated 08/19/13 under skin condition indicated fragile skin, coumadin therapy and skin tear/cut was checked.</p> <p>A review of Resident #17's nursing notes for the month of August revealed no mention of a skin tear to the back of the right hand.</p> <p>Review of the treatment administration record (TAR) for August revealed a treatment for a right lower shin skin tear which was discontinued on 08/20/13 due to being healed. There was no treatment for a skin tear to the back of the right hand.</p> <p>During an interview with NA # 3 on 08/22/13 at 9:20 AM, the NA revealed she was unaware of the skin tear to the right hand but Resident #17 did frequently have skin tears and attempted to remove her geri-sleeves. The NA added she reported any changes in skin condition to the nurses however since the right hand area had a dressing she would not have reported it because she would have imagined the nurses were aware and had applied the dressing to the area.</p> <p>During an interview with Nurse #3 on 08/22/13 at 10:15 AM, Nurse #3 revealed residents skin was monitored daily with care by the NAs and changes in skin were reported to the nurses as well as entered into the NA documentation system. Nurse #3 added the nurses were also responsible for a skin audit 3 times a week in which any change in skin condition was recorded.</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>During an interview with the wound nurse on 08/22/13 at 11:43 AM, the wound nurse stated incident reports were completed for falls, skin tears, bruises and areas of unknown origin.</p> <p>Review of the incident accident record for August indicated no new skin areas reported for Resident #17.</p> <p>Interview with the Director of Nursing (DON) on 08/22/13 at 2:46 PM revealed there was no information regarding when and how the skin tear had been sustained for Resident #17.</p> <p>Interview with Nurse # 2 on 08/22/13 at 4:18 PM revealed she was unaware of the skin tear and did not know how or when the Steri-Strips were placed there.</p> <p>Observation of resident #17 with Nurse #4 on 08/23/13 at 10:09 AM revealed the skin tear appeared old in nature, due to the dried blood to the left of the Steri-Strips and the lack of active bleeding. Nurse #4 added she was unaware of the skin tear to the back of the right hand. Nurse #4 stated skin checks were completed 3 times a week. Nurse # 4 also stated she had completed the most recent weekly status form on 08/19/13 and documented the skin tear to the shin but did not observe the other skin tear. The nurse added she frequently preformed Resident #17's skin audits and would do a complete body audit but would not always remove the geri-sleeves from her arms which sometimes covered her hands.</p> <p>During a follow-up interview with the DON on 08/23/13 at 10:30 AM, the DON stated on 08/22/13 when this surveyor brought the skin tear to her attention she wrote a treatment order for</p>	F 309			

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F 309	Continued From page 16 the area and added it to the TAR. The DON added she would have expected the nurse who had identified the skin tear and applied the Steri-Strips to have filed an incident report, notify the physician, initiated an order and documented in a nursing note the presence of the skin tear so that it would have been tracked and monitored in morning meeting for the next 5 days. The DON further stated she assessed the area and notified the physician.	F 309			
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, record review and staff interviews the facility failed to position a resident on an air mattress according to physical therapy recommendations and care plan for a resident with a pressure ulcer for 1 of 2 residents observed for pressure ulcers. (Resident #11) The findings included: Review of a facility policy entitled 'Pressure Ulcers - Assessment of Risk/Interventions' read in part: "the nursing staff will identify residents at	F 314	The facility will ensure 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. Director of Nursing provided education all clinical staff on the recommendations made by physical therapist regarding positioning resident on the air mattress for Resident #11. Care plans updated to show current state of wound. All other residents with pressure ulcers have been assessed for positioning by the Director of Nursing/designee. Director of Nursing/designee provided staff education on positioning residents per recommendation.	9/20/13 8/22/13 9/20/13	

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F 314	<p>Continued From page 17</p> <p>risk for pressure ulcers and implement interventions for prevention in an effort to reduce the incidence of pressure ulcers ... Evaluate the resident's response, or lack of response, to the pressure ulcer prevention interventions and revise the interventions accordingly."</p> <p>Resident #11 was admitted to the facility 09/02/09. Resident #11's diagnoses included bilateral above the knee amputation and diabetes. The most recent Annual Minimum Data Set dated 08/07/13 assessed Resident #11 as having severe cognitive impairment. The MDS further assessed her as having total dependence on staff for bed mobility, requiring the assistance of one person. The MDS assessed Resident #11 as having one unstageable pressure ulcer due to coverage of the wound bed by slough. The wound measured 4 cm x 3.5 cm.</p> <p>Review of Resident #11's care plan dated 05/21/13 revealed she was at risk for skin breakdown related to decreased mobility, incontinence, and bilateral above the knee amputation. The goal was that she would remain free of skin breakdown. The intervention was to reposition frequently as needed as well as provide incontinence care when needed. The care plan did not mention the resident's actual pressure ulcer or interventions for care and positioning.</p> <p>Review of the medical records revealed dressing changes were being done per physician orders. The Wound Progress record dated 07/25/13 recorded Resident #11's pressure wound as unstageable, measuring 3 x 3 cm, and assessed the wound bed as slough. An air mattress was initiated on 07/25/13. The Wound Progress</p>	F 314	<p>Director of Nursing/Designee/RN Treatment Nurse will assure that recommendations/orders for residents with specific positioning interventions to address pressure ulcers are followed. Monitoring will be done daily for 1 month; weekly for 2 months; and monthly for 3 months thereafter. Variances will be corrected immediately and staff education will be provided by the Director of Nursing/designee for non-compliance.</p>	9/20/13	

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F 314	<p>Continued From page 18</p> <p>Records dated 07/31/13, 08/06/13, and 08/15/13 recorded Resident #11's pressure wound as unstageable, measuring 4 x 3.5 cm, and assessed the wound bed as 100% slough.</p> <p>On 08/06/13 Resident #11 was referred to physical therapy. Review of the physical therapy plan of care read in part: "Reason for Referral: ...The wound has gotten worse with nursing care alone, therefore, patient referred to physical therapy for HVPC (high volt pulsed current) treatment to wound. Patient also complained of increased pain around sacral areaGoals - Patient will show increased healing of sacral wound ...Patient will achieve adequate positioning in bed in order to reduce pressure areas and reduce risk for skin breakdown."</p> <p>Review of physical therapy notes dated from 08/06/13 through 08/22/13 revealed Resident #11 needed maximum assistance for repositioning. The notes further indicated most days the resident was observed lying on her back in bed when the physical therapist arrived to perform therapy. A note on 08/21/13 revealed the physical therapist observed the resident was positioned with pillows under her stumps, bottom, and back. The note further indicated the physical therapist educated nursing staff not to put pillows under Resident #11's sacral area.</p> <p>On 08/22/13 at 8:50 AM an observation was made of Resident #11 on her bed lying on her back with her head elevated. Resident #11 was positioned with pillows between her sacral area and the air mattress.</p> <p>On 08/22/13 at 9:39 AM an observation was made of wound care for Resident #11. Upon</p>	F 314	<p>Administrator re-educated the MDS nurses on the importance of updating care plans that reflect the current state of those residents with pressure ulcers.</p> <p>RN/UB Auditor will monitor care plans for those residents having pressure ulcers for the current state of the wounds every 2 weeks for 3 months and randomly thereafter for 3 months.</p> <p>Findings from the QA audits will be reported during the monthly Quality Management Committee meeting for six months. Additional education and monitoring will be initiated for any identified concerns.</p>	<p>8/30/13</p> <p>9/20/13</p> <p>9/13/13</p>	

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F 314	<p>Continued From page 19</p> <p>arrival to the resident's room she was lying on her back on her air mattress with pillows under her buttocks and back. Observation of the Wound Nurse providing a dressing change to Resident #11's wound revealed the wound was a stage IV measuring 3.5 x 2 cm with a depth of 0.1 cm. There was bone showing in the wound bed. The wound was pink with granulation tissue and no slough was noted. After the dressing change the wound nurse positioned the resident on her side but placed pillows under her buttocks and back between the pressure ulcer and the air mattress.</p> <p>On 08/22/13 at 11:00 AM an observation was made of Resident #11 positioned on her air mattress with pillows under her buttocks and back between the pressure ulcer and the air mattress.</p> <p>On 08/22/13 at 2:30 PM an observation was made of Nursing Assistant (NA) #1 positioning Resident #11 on her air mattress after she had provided incontinence care. She positioned the resident on her back and placed pillows under her buttocks and back between the pressure ulcer and the air mattress.</p> <p>On 08/22/13 at 2:35 PM NA #1 stated she did not know exactly how to reposition the resident on the air mattress but the resident had complained of back pain.</p> <p>On 08/22/13 at 2:40 PM an interview was conducted with NA #2. NA #2 stated she was working on the shower team that day but that she had worked with Resident #11. NA#2 stated Resident #11 was not positioned correctly. NA #2 then proceeded to reposition Resident #11 by removing the pillows that were under the</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>resident's buttocks and rolling her on her right side with a pillow behind her back to maintain her in that position. The resident closed her eyes and made no complaints of being uncomfortable.</p> <p>On 08/23/13 at 9:58 PM an interview was conducted with the Wound Nurse. She stated she had tried to keep the resident positioned on her side but sometimes the resident complained of pain in her back. She stated the resident liked being positioned on her back with the pillows under her buttocks. She stated Resident #11 was placed on an air mattress on 07/25/13 when the wound became unstageable. The wound nurse offered no explanation as to why she placed a pillow between the resident's wound and the air mattress. She went on to explain she was unsure how information was communicated to other staff to provide the proper positioning.</p> <p>On 08/23/13 at 10:30 AM an observation was made of Resident #11 in bed lying toward her right side. She was positioned on pillows under each side of her body from her shoulders to her buttocks. The pillows were observed to be under the area of the resident's pressure ulcer.</p> <p>On 08/23/13 at 11:54 PM an interview was conducted with the Director of Nursing (DON). The DON explained that when staff used the wedge cushion the resident complained. She stated staff placed pillows around the resident in an oval shape around her body to make her comfortable. She stated she was unaware Resident #11's wound had worsened and was now a stage IV.</p> <p>After the DON was interviewed a physician's order was written on 08/23/13 for the wound</p>	F 314			

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F 314	Continued From page 21 center to evaluate the sacral wound for Resident #11. On 08/23/13 at 2:11 PM an interview was conducted with the DON. She stated there should have been communication between therapy and nursing regarding the positioning interventions for Resident #11's wound. She stated the resident should not have been positioned with a pillow between her pressure ulcer and the air mattress. On 08/23/13 at 2:20 PM an interview was conducted with the Physical Therapist. She stated Physical therapy started seeing the resident on 08/08/13. She stated they had started HVPC around the resident's wound. She stated positioning had been a problem with the use of pillows under the resident's wound while being on the air mattress. She explained the purpose of an air mattress was to relieve pressure, it defeated the purpose when there was a pillow between the resident's wound and the air mattress. She stated she had educated the staff and the resident regarding the importance of positioning the resident off of the wound and without the pillows between the wound and the air mattress.	F 314			
F 371 SS=E	483.35(j) 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	F 371	The facility will ensure sanitary conditions – food will be stored, prepared, distributed & served under sanitary conditions	9/20/13	

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/23/2013
NAME OF PROVIDER OR SUPPLIER CLEVELAND PINES NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1404 N LAFAYETTE ST SHELBY, NC 28150	
(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 22 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to monitor the temperature of the foods on the tray line prior to food service and failed to contain hair under cap or hair restraint while in the kitchen. The findings include: 1. Review of the facility's undated guideline "Meal Temperatures", read in part, "The temperatures of the foods will be taken and recorded on the temperature checklist or menu prior to the start of each meal at the steam table." Observation of the dinner tray line was conducted on 08/21/13 from 4:23 PM until 5:15 PM. The main meal consisted of a chef salad and the alternate was baked ham, o' gratin potatoes and greens. At 4:25 PM the alternate was observed on the steam table. At 4:40 PM the cook plated a chef salad and a bowl of o' gratin potatoes. At 4:41 PM the plated meal tray was placed on the food cart. At 4:42 PM the surveyor requested temperatures be taken of foods on the steam table. At 4:43 PM the cook obtained a thermometer and began to obtain temperatures for the foods on the steam table. At 4:45 PM the cook obtained a temperature of 130 degrees (°) Fahrenheit (F) for the chopped ham. The cook removed the aluminum pan of chopped ham for reheating. At 4:52 PM the cook confirmed she did not monitor the temperature of the food when it was placed on the steam table but had taken the temperature after the food was prepared earlier. The cook added she did not document the	F 371	Re-education provided to the Dietary Staff on taking and recording temperatures prior to serving meals per Federal, State and local authorities. The Dietary Manager/designee will monitor the tray line daily for 1 month to ensure the temperature of the food is at proper temperature prior to being serviced, then monitor weekly for 5 months. Education will be provided for non-compliance. Variances will be corrected as identified. QA Monitoring Tool will be utilized by Dietary to ensure ongoing compliance. Findings will be reviewed monthly by the Administrator/designee. Administrator re-educated Dietary Manager on regulations regarding regulations on distribution and serving for under sanitary conditions and failing to contain hair under a cap or hair restraint while in the kitchen. Administrator will monitor Dietary Manager for compliance with wearing a hair restraint daily for 1 month then randomly for 6 months.	9/7/13 9/20/13 9/20/13 8/23/13 9/20/13

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F 371	<p>Continued From page 23</p> <p>temperatures taken after preparing the food but typically waited and documented that temperature on the food temperature log after the meal had been served.</p> <p>An interview with the dietary manager (DM) was conducted on 08/21/13 at 5:21 PM. The DM confirmed temperature monitoring should be conducted on all foods on the tray line prior to food service.</p> <p>2. Review of the facility's policy, revised dated of June 2012 "Sanitary Conditions", read in part, "dietary staff were to wear hair restraints (e.g. net, hat or beard restraint) to prevent hair from coming in contact with food surfaces."</p> <p>On 08/20/13 from 10:20 AM -10:55 AM the dietary manager (DM) was observed in the kitchen not wearing a hair net or cap. The DM entered the walk in refrigerator, dry storage area and cooks prep areas. On 08/21/13 at 3:45 PM the DM was observed in the kitchen during dinner preparation. The DM was observed again with no hair net and walking throughout the kitchen while foods were observed uncovered in the cooks prep area.</p> <p>On 08/21/13 at 5:21 PM the DM confirmed she expected staff to wear a hair restraint or cap as long as the hair was fully covered and not exposed. The DM added she typically did not wear a hair restraint in the kitchen because she did not work with the food.</p> <p>On 08/23/13 at 2:27 PM the Registered Dietician (RD) was interviewed. The RD confirmed that all staff working in the kitchen, walking through the kitchen or in the kitchen at all should wear a hair</p>	F 371	<p>Findings from the QA audits will be reported during the monthly Quality Management Committee meeting for six months. Additional education and monitoring will be initiated for any identified concerns.</p>	9/13/13	

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F 371	Continued From page 24 restraint.	F 371			

