STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC Blowing Rock Rehabilitation & Davant Extended Care Center	418 CHESTNUT ST BLOWING ROCK, NC 28605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to ensure dignity during dining when staff failed to remove a resident's plate from the table after she coughed and vomited in it in front of residents who were eating lunch during 1 of 1 meal observation. (Resident #36, #4 and #6). The findings included: 1. Resident #36 was admitted to the facility on 07/05/13 with diagnoses that included chronic lung disease, heart disease, anxiety and depression. The most recent quarterly Minimum Data Set (MDS) dated 08/22/13 indicated Resident #36 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #36 required supervision by 1 staff when eating. During continuous observations in a restorative dining room on 11/19/13 at 11:55 AM Resident #36 was seated at a table and started coughing when she began to eat lunch. A restorative aide was assisting residents at another table to the right of where Resident #36 was seated and called for Nurse #1 to come into the dining room. Resident #36 told Nurse #1 she felt she had	F 241	**F241 SS = D** **483.15 (a) Dignity and Respect of Individuality** **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** On December 12/ 2013,The Social Service Director and the Interim Director of Nursing have apologize and reassure both residents that the staff are being in-serviced to remove meal plates from dining area anytime there is bodily fluid expelled onto them. **Address how the corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice.** The team leader will audit the dining room 3 times per week during a mealtime to ensure that meal trays are being removed from the dining area immediately if they are unpleasant to look at or having bodily fluid. Beginning on Dec 12 th 2013 audits will take place for the next 3 months.	12/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Hayes LNHA | TITLE: Administrator | (X6) DATE: 12/13/13

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.

DSR Raleigh Mail Room WRO DEC 16 2013 by: SKH

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F 241	Continued From page 1 something stuck in her throat and she couldn't get it to go down. Nurse #1 told Resident #36 to sit up straight and as she straightened up she coughed and vomited a large amount of phlegm into her left hand and onto her plate. Nurse #1 gave Resident #36 a napkin to wipe her mouth and hand but Resident #36 continued to cough and at 12:10 PM Nurse #1 transported Resident #36 out of the dining room and left Resident #36's plate on the table uncovered while 2 residents seated at the table were still eating their lunch. During an interview on 11/19/13 at 2:38 PM Nurse #1 confirmed she was called into the dining room during lunch because Resident #36 was coughing. She stated Resident #36 told her she had something stuck in her throat and she was concerned Resident #36 might choke. She confirmed Resident #36 kept coughing and then vomited a large amount of phlegm into her hand and onto her plate. She stated she took Resident #36 out of the dining room to her room and Resident #36 told her she was so embarrassed when she started coughing because she did not want to make a scene in front of other residents in the dining room. Nurse #1 confirmed she did not remove Resident #36's plate from the table and stated there were 2 Nurse Aides and a Restorative Aide in the dining room during lunch and she expected one of them would have removed the plate from the table when she took Resident #36 out of the dining room. During an interview on 11/19/13 at 2:44 PM Nurse Aide (NA) #1 confirmed she was in the dining room during lunch and fed residents who were seated at a table to the left side of Resident #36's table. She stated Resident #36 was seated at a table with other residents who fed	F 241	The Activities Director will ask in the monthly resident council meeting if the dining atmosphere is pleasant. Beginning with the next resident council meeting set for December 16th 2013. **Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur** All clinical staff including nurses, CNA's, activities, unit secretary's, will be educated thru our TEDS on line program on the removal of trays with body fluid contents immediately from the dining area. The training began on December 9th and will be completed by all staff by December 30th 2013. Removal of tray immediately in the dining area if it is unpleasant to look at or has bodily fluid on it will be covered during the clinical orientation by the Social Service Director under Dignity. Starting on the Next orientation date scheduled for January 21st, 2013.	

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F 241	Continued From page 2 themselves and only needed cueing to eat when they were not eating their food. She explained Resident #4 was seated next to Resident #36 on her left side and Resident #6 was seated across and diagonally to the left of Resident #36. She stated Resident #36's plate was not removed from the table until after residents had left the dining room when all residents plates were picked up and tables were cleaned. She further stated they should have removed Resident #36's plate since residents were still eating but she was assisting other residents and didn't think to do it. During an interview on 11/19/13 at 3:01 PM with NA #2 she confirmed she was in the dining room during lunch and assisted residents who needed to be fed at another table to the left side of the dining room next to where Resident #36 was seated. NA #2 stated she did not pick up Resident #36's plate after she coughed and vomited in it because she was feeding another resident. She confirmed the plate was picked up with other resident's plates at the end of the meal service after all residents had left the table. During an interview on 11/19/13 at 3:15 PM the Restorative Aide confirmed she was in the dining room during lunch and was seated at a table with residents who received restorative therapy that was located to the right of the table next to where Resident #36 was seated. She explained she called for Nurse #1 to come into the dining room when Resident #36 started coughing because she thought she was choked. She stated if a resident vomited into their plate they should cover the plate with a lid so it wouldn't bother other residents who were still eating but confirmed Resident #36's plate was not covered after she vomited in it.	F 241	**Indicate how the facility plans to monitored it performance to make sure that the solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for it's effectiveness. The POC is integrated into the quality assurance system of the facility.** All clinical staff will be educated on removing plate of food immediately from the dining area if it is unpleasant to look at or has bodily fluid contents on it. This education will be completed by December 20th 2013 This education will be incorporated into the new employee orientation held the 3rd Tuesday of each month, beginning with the January 21st, 2014 orientation. The Dining rooms, during mealtimes, will be monitored 3 times a week by the team leader for the next 3 months to ensure there are not plates of food being left at the table that are unpleasant to look at or have bodily fluid on them. The monitoring will begin on Dec 12th 2013. Findings of audits will be taken to the PI committee meeting for the next 3 months. Beginning with the next PI meeting set for Dec 19th. 2013.	

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F 241	Continued From page 3 During an interview on 11/20/13 at 9:19 AM with Resident #36 she stated she remembered coughing at lunch yesterday. She further stated she felt like something was stuck in her throat and it really scared her and upset her because she thought she was choking. She explained she preferred to eat in her room and might not go back to the dining room since her coughing spell in front of the other residents upset her yesterday. During an interview on 11/22/13 at 11:18 AM the Director of Nursing stated it was her expectation that staff should have removed Resident #36's plate from the table after she had coughed and vomited in it. She further stated it was not sanitary or appetizing for the plate to remain on the table while residents were still eating lunch. 2. Resident #4 was admitted to the facility on 08/20/13 with diagnosis that included heart disease, anxiety and depression. The admission Minimum Data Set (MDS) dated 09/10/13 indicated Resident #4 had no short term or long term memory problems and had no impairment in cognition for daily decision making. The MDS further indicated Resident #4 was independent with eating and required set up help only. During continuous observations in a restorative dining room on 11/19/13 at 11:55 AM Resident #36 was seated at a table and started coughing when she began to eat lunch. A restorative aide was assisting residents at another table to the right of where Resident #36 was seated and called for Nurse #1 to come into the dining room. Resident #36 told Nurse #1 she felt she had something stuck in her throat and she couldn't get it to go down. Nurse #1 told Resident #36 to sit	F 241	The Activities Director will bring the findings of the audits of the resident council meetings to the PI committee meeting for the next 3 months beginning with the next PI meeting set for Dec. 19th 2013.	

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F 241	Continued From page 4 up straight and as she straightened up she coughed and vomited a large amount of phlegm into her left hand and onto her plate. Nurse #1 gave Resident #36 a napkin to wipe her mouth and hand but Resident #36 continued to cough and at 12:10 PM Nurse #1 transported Resident #36 out of the dining room and left Resident #36's plate on the table uncovered while 2 residents seated at the table were still eating their lunch. During an interview on 11/19/13 at 2:38 PM Nurse #1 confirmed she was called into the dining room during lunch because Resident #36 was coughing. She stated Resident #36 told her she had something stuck in her throat and she was concerned Resident #36 might choke. She confirmed Resident #36 kept coughing and then vomited a large amount of phlegm into her hand and onto her plate. She stated she took Resident #36 out of the dining room to her room and Resident #36 told her she was so embarrassed when she started coughing because she did not want to make a scene in front of other residents in the dining room. Nurse #1 confirmed she did not remove Resident #36's plate from the table and stated there were 2 Nurse Aides and a Restorative Aide in the dining room during lunch and she expected one of them would have removed the plate when she took Resident #36 out of the dining room. During an interview on 11/19/13 at 2:44 PM Nurse Aide (NA) #1 confirmed she was in the dining room during lunch and fed residents who were seated at a table to the left side of Resident #36's table. She stated Resident #36 was seated at a table with other residents who fed themselves and only needed cueing to eat when they were not eating their food. She explained	F 241		

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F 241	Continued From page 5 Resident #4 was seated next to Resident #36 on her left side and Resident #6 was seated across and diagonally to the left of Resident #36. She stated Resident #36's plate was not removed from the table until after residents had left the dining room when all residents plates were picked up and tables were cleaned. She further stated they should have removed Resident #36's plate since residents were still eating but she was assisting other residents and didn't think to do it. During an interview on 11/19/13 at 3:01 PM with NA #2 she confirmed she was in the dining room during lunch and assisted residents who needed to be fed at another table to the left side of the dining room next to where Resident #36 was seated. NA #2 stated she did not pick up Resident #36's plate after she coughed and vomited in it because she was feeding another resident. She confirmed the plate was picked up with other resident's plates at the end of the meal service after all residents had left the table. During an interview on 11/19/13 at 3:15 PM the Restorative Aide confirmed she was in the dining room during lunch and was seated at a table with residents who received restorative therapy that was located to the right of the table next to where Resident #36 was seated. She explained she called for Nurse #1 to come into the dining room when Resident #36 started coughing because she thought she was choked. She stated if a resident vomited into their plate they should cover the plate with a lid so it wouldn't bother other residents who were still eating but confirmed Resident #36's plate was not covered after she vomited in it. During an interview on 11/20/13 at 4:05 PM with	F 241		

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F 241	Continued From page 6 Resident #4 she stated she was seated on Resident #36's left side yesterday during lunch in the dining room and remembered Resident #36 coughed and vomited in her plate. She stated it really bothered her and upset her and she tried to finish her lunch but finally got up and left because Resident #36's plate was left on the table uncovered. She confirmed there were residents who were still seated at the table and were eating their lunch when she left the dining room. During an interview on 11/22/13 at 11:18 AM the Director of Nursing stated it was her expectation that staff should have removed Resident #36's plate from the table after she had coughed and vomited in it. She further stated it was not sanitary or appetizing for the plate to remain on the table while residents were still eating lunch. 3. Resident #6 was admitted to the facility on 07/29/05 with diagnoses that included heart disease, anxiety and depression. The most recent quarterly Minimum Data Set (MDS) dated 08/31/13 indicated Resident #6 had no short term or long term memory problems and had no impairment in cognition for daily decision making. The MDS also indicated Resident #6 was independent with eating and required set help only. During continuous observations in a restorative dining room on 11/19/13 at 11:55 AM Resident #36 was seated at a table and started coughing when she began to eat lunch. A restorative aide was assisting residents at another table to the right of where Resident #36 was seated and called for Nurse #1 to come into the dining room. Resident #36 told Nurse #1 she felt she had something stuck in her throat and she couldn't get	F 241		

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F 241	Continued From page 7 it to go down. Nurse #1 told Resident #36 to sit up straight and as she straightened up she coughed and vomited a large amount of phlegm into her left hand and onto her plate. Nurse #1 gave Resident #36 a napkin to wipe her mouth and hand but Resident #36 continued to cough and at 12:10 PM Nurse #1 transported Resident #36 out of the dining room and left Resident #36's plate on the table uncovered while 2 residents seated at the table were still eating their lunch. During an interview on 11/19/13 at 2:38 PM Nurse #1 confirmed she was called into the dining room during lunch because Resident #36 was coughing. She stated Resident #36 told her she had something stuck in her throat and she was concerned Resident #36 might choke. She confirmed Resident #36 kept coughing and then vomited a large amount of phlegm into her hand and onto her plate. She stated she took Resident #36 out of the dining room to her room and Resident #36 told her she was so embarrassed when she started coughing because she did not want to make a scene in front of other residents in the dining room. Nurse #1 confirmed she did not remove Resident #36's plate from the table and stated there were 2 Nurse Aides and a Restorative Aide in the dining room during lunch and she expected one of them would have removed the plate from the table when she took Resident #36 out of the dining room. During an interview on 11/19/13 at 2:44 PM Nurse Aide (NA) #1 confirmed she was in the dining room during lunch and fed residents who were seated at a table to the left side of Resident #36's table. She stated Resident #36 was seated at a table with other residents who fed themselves and only needed cueing to eat when	F 241		

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F 241	Continued From page 8 they were not eating their food. She explained Resident #4 was seated next to Resident #36 on her left side and Resident #6 was seated across and diagonally to the left of Resident #36. She stated Resident #36's plate was not removed from the table until after residents had left the dining room when all residents plates were picked up and tables were cleaned. She further stated they should have removed Resident #36's plate since residents were still eating but she was assisting other residents and didn't think to do it. During an interview on 11/19/13 at 3:01 PM with NA #2 she confirmed she was in the dining room during lunch and assisted residents who needed to be fed at another table to the left side of the dining room next to where Resident #36 was seated. NA #2 stated she did not pick up Resident #36's plate after she coughed and vomited in it because she was feeding another resident. She confirmed the plate was picked up with other resident's plates at the end of the meal service after all residents had left the table. During an interview on 11/19/13 at 3:15 PM the Restorative Aide confirmed she was in the dining room during lunch and was seated at a table with residents who received restorative therapy that was located to the right of the table next to where Resident #36 was seated. She explained she called for Nurse #1 to come into the dining room when Resident #36 started coughing because she thought she was choked. She stated if a resident vomited into their plate they should cover the plate with a lid so it wouldn't bother other residents who were still eating but confirmed Resident #36's plate was not covered after she vomited in it.	F 241		

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F 241	Continued From page 9 During an interview on 11/20/13 at 9:00 AM Resident #6 confirmed she was sitting across the table and was facing Resident #36 yesterday during lunch and remembered Resident #36 coughed and vomited in her plate. She stated it made her sick to her stomach and she lost her appetite and couldn't finish her lunch. She described it as awful and disgusting because no one covered the plate with a lid or cleared the plate off the table after Resident #36 coughed and vomited in it and there were residents still seated at the table who were trying to eat their lunch. During an interview on 11/22/13 at 11:18 AM the Director of Nursing stated it was her expectation that staff should have removed Resident #36's plate from the table after she had coughed and vomited in it. She further stated it was not sanitary or appetizing for the plate to remain on the table while residents were still eating lunch.	F 241		