3/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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, staff, resident interviews and record reviews, the facility failed to provide a dignified dining experience for 2 of 4 residents that required assistance with feeding (Residents # 46 and #108). The findings included: Resident #46 was admitted on 7/6/14 with diagnoses included diabetes mellitus, stroke and hypertension. Review of resident ' s Minimum Data Set (MDS), dated 1/6/15, revealed that the resident had severe impaired cognition. The resident required extensive assistance with eating (one assistant). Resident #108 was admitted on 12/12/14 with diagnoses included depression and hip fracture. Review of resident ' s minimum data set (MDS), dated 1/16/15, revealed resident ' s moderate impairment cognition. Resident #108 required extensive assistance with eating (one person). On 1/29/15 during continuous observation from 12:00 to 1:15 PM, resident #108 was observed sitting in the dining room near the empty table with no food or water. During an interview at 12:45 PM, Resident #108 indicated that she was hungry and said that she was ready to " eat a long time ago. " On 1/29/15 during continuous observation from 12:00 to 1:15 PM, resident #46 was observed	F 241	Resident # 108 and Resident # 46 were immediately given their trays and assistance with eating. Apologies were given to both residents by the Director of Nursing. All residents requiring assistance with eating who eat in the dining room are at risk for this deficient practice. All staff have been reeducated concerning the process for meal delivery in the dining room. One component of this process is that when the trays arrive in the dining room, the CNAs assigned to the dining room set up and begin assisting those who require total assistance with eating while the rest of the CNAs deliver and set up the meal for those who are independent or only require observation while they are eating. There will be one CNA to every two residents who require total assistance with eating in the dining room to ensure that no one will have to wait.	03/01/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ima Billings	Administrator	02/26/2015

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 241	Continued From page 1 sitting in the dining room, in his Geri chair near the table without food or water. During an interview attempt at 12:45 PM, resident #46 could not verbalize his answers. The resident looked sadly at other people plates. When the resident was asked if he wanted to eat, he nodded his head and pointed at the empty table with his hands. When the tray came to his table, resident #46 began to eat eagerly. During the lunch observation on 1/29/15, the meal tray cart arrived at the dining room at 12:20 PM. There were sixteen residents in wheelchairs, sitting around seven tables when two aides began to serve the food. While most of the residents could feed themselves, four of them required feeding assistance. After the meals for five tables with residents were set up, both aides began to assist two of the residents with feeding. Two residents (residents #46 and #108) were observed sitting unattended near their empty tables without water or meals until 1:00 PM, while two aides continued to feed other residents. On 1/29/15 at 12:45 PM, during the interview, aide #1 stated that there were two aides assigned to the dining room today. The aide #1 added that she wanted to assist resident #46 after she finished feeding the first resident. On 1/29/15 at 12:45 PM, during the interview, aide #2 stated that there were two aides assigned for the dining room. She stated that she participated in tray distribution, meal set up and did not have any time to serve resident #108. The director of nursing (DON) was called and came to the dining room at 1:00 PM. She asked the aides about the dining room assignment of the aides and both of them confirmed that only two were assigned to dining room for the purpose of assisting with lunch today. On 1/29/15 at 1:00 PM, during the interview, the	F 241	The dining room will be monitored during meals by a staff member not assigned to patient care. This monitoring will include noting the time the trays arrive in the dining room, the residents that are in the dining room who require total assistance with eating, the number of CNAs assigned to assist them, and the time when that assistance begins for each resident. This monitoring will be documented on the Dining Room Observation Monitoring tool daily for each meal x 7days, 5 days a week for each meal x2 weeks, every lunch and dinner meal 5 days a week x 2 weeks, a lunch and a dinner meal weekly x 7 weeks. The Director of Nursing will report the findings of the monitoring to the Quality Assurance/Performance Committee meeting monthly for the duration of the monitoring timeframe for review and recommendations.	03/01/15

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F 241	Continued From page 2 director of nursing (DON) stated that she was unaware of residents, who had to wait for their turn to eat. She explained that the facility had organizational issue with tray distribution and feeding of the residents on time. She added that the staff should prioritize assignments of meal times. The DON indicated that she expected residents to be fed when the food arrived. At 1:05 PM the DON began to feed the resident #46.	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to provide activities of daily living care for 1 of 3 sampled residents (Resident #46). The findings included Resident #46 was admitted on 7/6/14. The diagnoses included hypertension, diabetes and cerebral vascular disease. Review of his Minimum Data Set (MDS), dated 1/6/15, revealed severely impaired cognition. Resident#46 required total assistance for mobility, transfer, dressing, toileting, extensive assistance for personal hygiene and eating. Review of the updated care plan dated 1/20/15 identified the problem as: resident had an	F 312	Resident #46 was shaved and bathed. Special attention was paid to exfoliating his feet. Lotion was applied after the bath to all of the resident's skin. All residents who are dependent in Activities of Daily Living are at risk for this deficient practice. Nursing staff has been reeducated concerning the expectations of a resident bath or shower. This reeducation included the expectations that the bath should allow for dry/dead skin be gently exfoliated, that skin be moisturized with every bath and in between bath days where necessary, that shaving happen for male residents with each bath and in between bath days where necessary by the presence of whiskers, that female residents have facial hair removed with the bath and in between bath days were necessary by the presence of whiskers, and that fingernails and toenails are trimmed and clean with each bath and as needed on none bath days.	03/01/15

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F 312	Continued From page 3 activities of daily self-care performance deficit, related to cerebral vascular disease with hemiplegia and contracture of left hand and wrist. The goal included Resident#46 would improve current level of function in ADLs and mobility. Resident was totally dependent on staff for bathing/showers, dressing and personal hygiene and care. The approaches included to provide bath/shower twice weekly and as necessary, repositioning and turning in bed every 2 hours and skin inspection daily with care. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Review of the activities of daily living schedule for December 18, 2014 through January 29, 2015, revealed there was no documentation of baths completed for Resident #46 in accordance with designated bath days. During an observation on 1/29/15 at 1:00PM, resident seated in dining room unshaven with large volume of whiskers uncut. He was nicely dressed, but skin was dry all over especially the leg area. Resident#46 continued to pull up his pant leg and pull off socks. Resident#46 would over load his spoon it not carefully watched. .Resident#46 pulled off socks at least once and feet were dry and had large volume of crust, dirt caked between toes. NA#1 put sock back on Resident#46 feet. During an interview on 1/29/15 at 2:00PM, NA#3 assigned to perform personal hygiene care Resident #46 this morning, stated that she gave the resident a partial bath which included washing of the face, under arms and bottom. She indicated that he should have been shaved but she ran out of time and acknowledged that the	F 312	The staff nurses have been reeducated concerning their role in monitoring the ADL care of each of their assigned residents. The reeducation includes documenting verification of inspection of the results of the schedule baths on their assignments. This will be documented on the Shower/Bath Follow up Monitoring Tool. This monitoring will be documented for every scheduled bath daily for 8 weeks. The staff nurses have been reeducated to verify the completion of the documentation of ADL care, including showers/baths, by the end of the shift. This verification will be documented on the Daily Point of Care Documentation monitoring daily for 8 weeks.	03/01/15

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F 312	Continued From page 4 resident had not been shaved in several days. NA#3 removed resident ' s socks and his feet were crusted, excessive dry skin, large volume of dirt built up. NA#3 added that Resident#46 ' s bath/shower schedule was for MWF on 3rd shift. NA#3 stated that was when Resident#46 would get the full bath. NA looked at resident's feet and confirmed they were extremely dried, scaly and crusted heavily between the toes, ankles, heels. NA confirmed that the feet/legs did not look like they have been washed. Third shift was unavailable for interview. During an observation on 1/29/15 at 2:15PM, the DON, observed Resident#46 ' s feet and confirmed the resident's feet had not been washed and had large volume of dried skin, crust between toes, ankles/heels. DON acknowledged after review of the bath schedule Resident#46 bath should have taken place on 3rd shift on Wed. Her expectation was that when the resident was bathe/shower all parts of the body should be cleaned and moisturized /lotion should be applied. She indicated that there was no partial bath practices in the facility.	F 312	The Director of Nursing or Unit Manager will gather the Shower/Bath Follow up Monitoring Tools daily to ensure completion and spot check 4 residents randomly a day to assess the effectiveness of the monitoring. This will be documented on the Bathing Verification monitoring tool daily x 7days and then 5 days a week for 7 weeks. The Director of Nursing or Unit Manager will check completion of documentation of ADLs every 24 hours and document on the Point of Care Documentation monitoring tool daily x 7days and then 5 days a week for 7 weeks. The Director of Nursing will report the results of the monitoring to the Quality Assurance/Performance Improvement Committee monthly for the duration of the monitoring schedule for review and recommendations.	