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	345377	A. BUILDING _____ B. WING _____	C 04/30/2015

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GREENFIELD PLACE	**2575 W 5TH STREET GREENVILLE, NC 27834**

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to incorporate a care concern expressed on behalf of 1 of 10 sampled residents (Resident # 66) into its grievance system in order for a resolution to be reached. Findings included: The facility's Grievances and Complaint Resolution policy (revised 11/07/12) documented, "Any resident, his/her representative, family member or employee has the right to voice grievances without discrimination or reprisal. The grievance will be investigated and resolved in a timely manner. The resolution progress and the outcome will be communicated to the resident, his/her representative, family member or employee timely." Resident #66 was admitted to the facility on 040/6/12 and readmitted on 01/27/14. The resident's documented diagnoses included history of sacral pressure ulcer, anorexia, malnutrition, adult failure to thrive, and Alzheimer's dementia. Nurse #1's 04/12/15 interdisciplinary progress note documented, "Family upset that resident was up longer "than 4 hours today." ____ (name of family member) stated resident was gotten up at 10:30 (AM) and went to church in facility and was still up when he got back this PM--resident	F 166	1. Resident #66 was placed back in bed after supper and made comfortable on 4-12-15. Staff will be inserviced on May 18th thru May 31st regarding the importance of reporting any concerns or grievances timely. 2. The Facility Grievance and Complaint Resolution Policy was revised on 5-15-15 to include that the Administrator will create a log and log all grievances and concerns that he receives. Staff will be inserviced on May 18th thru May 31st regarding the revision in this policy and the importance of reporting grievances and complaints timely as is identified in the policy. The 24 hour reports will be audited 5 times a week to assure that all concerns/grievances are identified and investigated. 3. The Administrator and Social Worker will compare logs weekly x 4 then monthly x 2 to assure that all grievances are investigated timely. Facility staff will be inserviced monthly x 2 then quarterly x 2 regarding the importance of following the facility Grievance and Complaint Resolution Policy and reporting of	5/31/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/21/2015

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F 166	Continued From page 1 put back to bed and made comfortable after supper." Review of the facility's grievance log revealed no grievance was filed on behalf of Resident #66 regarding the family's 04/12/15 concern that the resident was left sitting up too long. At 9:17 AM on 04/30/15 Nurse #1 stated she thought she had completed a grievance form to capture the concerns Resident #66's family expressed on 04/12/15. She reported the family was concerned because they stated the resident was out of bed in her geri-chair at 10:30 AM and remained in this chair until they returned later in the afternoon between 5:00 PM and 6:00 PM. According to Nurse #1, the resident was placed back to bed after she finished eating her supper meal, but the nurse commented she was unsure what had transpired to cause the resident to be in one position in her chair for so long. The nurse reported the purpose of the facility's grievance system was to allow the facility to investigate problems, and develop interventions to prevent them from occurring again. She commented the complainant was also informed of the investigation outcome and plan of correction to develop an atmosphere of good customer service. At 9:40 AM on 04/30/15 the facility's social worker (SW) stated she never received a grievance form from the administrator so she could log in the 04/12/15 concerns regarding Resident #66's lack of care. She reported if the form had been completed it would have been placed in one of the baskets at the nursing stations, collected, forwarded to the administrator who verified that it involved a legitimate concern, discussed in	F 166	grievances/concerns timely. 4. The results of these comparisons will be taken to the facility QA&A committee. The committee will make recommendations based on the finding of these audits.	

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F 166	Continued From page 2 morning meeting, placed on the grievance log, and assigned to someone associated with nursing to investigate. According to the SW, anytime a family member, resident, or staff member expressed concerns about resident well being, a grievance form was completed so the situation could be investigated, and the problem could be addressed so that resident care would improve. At 9:52 AM on 04/30/15 the administrator stated he did not maintain a list of the grievance forms he reviewed and then forwarded to the SW. He stated a grievance form was to be completed anytime a family member, resident, or staff member had concerns about the welfare of residents. According to the administrator, the concern expressed by Resident #66's family on 04/12/15 should have been run through the facility's grievance system.	F 166		
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 observation, staff interview, and record review the facility failed to reposition 1 of 3	F 314	1. Resident #66 was returned to bed. A physicians order was written for resident	5/31/15

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F 314	Continued From page 3 sampled residents (Resident #66) with current or healed pressure ulcers who remained in a geri-chair throughout the day, and had a physician order to avoid sacral pressure. Findings included: Resident #66 was admitted to the facility on 04/06/12 and readmitted on 01/27/14. The resident's documented diagnoses included history of sacral pressure ulcer, anorexia, malnutrition, adult failure to thrive, and Alzheimer's dementia. Review of physician orders, treatment progress notes, and wound consultation notes revealed an active physician order, initiated on 04/21/14, to avoid sacral pressure. A 06/21/14 wound consultation note documented Resident #66's stage IV sacral ulcer, which had been treated using a wound vac and required use of an indwelling catheter to prevent contamination, was healed. Treatment progress notes documented the sacral ulcer reopened on 09/26/14, presenting as a stage II wound, and healed on 12/12/14. The resident's 01/11/15 annual minimum data set (MDS) documented she had short and long term memory impairment, was severely impaired in decision making, required extensive assistance by two staff members with transfers, was at risk of developing pressure ulcers, and had a stage II pressure ulcer present on the previous MDS assessment. The resident's 01/13/15 care area assessment (CAA) documented she was bed/chair bound, was total care, and had a stage II sacral ulcer which healed on 12/12/14. Pressure ulcer risk was identified as a problem to address in the resident's care plan.	F 314	#66 stating, "up for 2 hours daily then return to bed" to assist with maintaining skin integrity to prevent a new pressure ulcer from developing. Staff will be inserviced May 18th thru May 31st regarding the importance of turning and repositioning residents in bed and while up in chairs to maintain skin integrity, promote healing and prevent pressure ulcers from developing. 2. Staff will be inserviced May 18th thru May 31st regarding the importance of turning and repositioning residents in ed and while up in chairs to maintain skin integrity, promote healing and prevent pressure ulcers from developing. A Directed Inservice on Pressure Ulcers was conducted from May 18th thru May 31st. The Directed Inservice will be accomplished via a DVD obtained from the Laupus Library at the Brody School of Medicine at Vidant Medical Center. The DVD is titled Skin Integrity and Pressure Ulcers. This DVD will be shown to Nurses and Nursing Assistants. 3. A list of resident requiring extensive assist or who are total care was generated. To assure compliance with turning and repositioning a Direct Observation worksheet was developed. This worksheet will be used to directly observe residents over a 3 hour period to assure that they are turned and repositioned timely to maintain skin integrity, promote healing and prevent pressure ulcers from developing. These direct observations will be completed on a	

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F 314	Continued From page 4 The resident's care plan, last updated on 04/13/15, identified "Skin breakdown at risk for r/t (in regard to) decreased mobility, B & B incont (bowel and bladder incontinence), poor intake, risk for weight loss" as a problem. Interventions to this problem included using pressure reducing devices to bed/chair, assisting/encouraging to turn/reposition routinely, turning every two hours, and limiting sitting to meal times only. On 04/29/15 at 8:45 AM Resident # 66 was observed in her geri-chair eating breakfast. This geri-chair had a cushion in the seat. The resident remained in her geri-chair after her meal tray was removed. The resident was wheeled to the main dining room in her geri-chair at 11:30 AM, but taken back to her room where she ate lunch in her geri-chair between 12:40 PM and 1:20 PM, was wheeled to the activity room in her geri-chair for a group event at 1:50 PM and remained there until 3:15 PM, was taken back to her room, and remained in her geri-chair until 5:00 PM. On 04/29/15 at 5:05 PM, after surveyor intervention, the condition of Resident #66's bottom was checked by nursing assistants. The resident's bottom was not red, but there was an imprint on the resident's bottom from a wrinkle in her brief and from the edges of the brief. On 04/29/15 at 5:12 PM nursing assistant (NA) #1, assigned to care for Resident #66, stated because the resident had a bad pressure ulcer on her bottom previously she was not to remain up in her chair more than two hours at a time. However, she reported the staff tried to get the resident out of bed twice a day, once on first shift and once on second shift. The NA commented	F 314	minimum of 10 residents a week for 3 weeks then monthly x 2 weeks. Our resident sample will be taken from the generated list of residents requiring extensive assist or who are total care. 4. The results of these direct observations will be taken to the facility QA&A committee. The committee will make recommendations based on the findings of these observations.	

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F 314	Continued From page 5 Resident #66 was up in her chair when she started her shift, but she did not realize that the resident had been up in the chair since breakfast. She stated the resident stayed in one position when up in her geri-chair with the cushion in the seat. At 8:53 AM on 04/30/15 physical therapist (PT) #1 stated Resident #66 had a foam cushion in her geri-chair. He reported if the resident stayed sitting in her geri-chair for more than two hours she should be lifted off the cushion every 45 minutes to avoid "hot spots" which could eventually cause pressure problems to the bottom/sacrum (the staff was not observed doing this). At 9:07 AM on 04/30/15 NA #2, assigned to care for Resident # 66, stated the resident stayed up in her geri-chair for no more than two hours at a time because she had a pressure ulcer on her bottom in the past. She reported she tried to get the resident up to the chair twice during first shift with some time in the bed in between. She commented there was no need to lift the resident off the cushion in her geri-chair because the resident never stayed in the chair for more than two hours at a time. At 12:18 PM on 04/30/15 the director of nursing stated Resident #66 was not supposed to be up in her geri-chair for more than a couple of hours at a time. She also reported she would expect staff to reposition the resident occasionally when she was out of bed in her geri-chair.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		5/31/15

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F 325	Continued From page 6 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide a sandwich with all meals, as implemented by the registered dietitian (RD), for 1 of 1 sampled residents (Resident #55) who experienced gradual weight loss. Findings included: Resident #55 was admitted to the facility on 02/19/08. The resident's documented diagnoses included cerebrovascular accident with left hemiplegia, dysphagia, and contractures. A 11/12/13 physician order placed Resident #55 on a finger food diet with nectar thick liquids. The resident's Monthly Record of Vital Signs and Weights documented in November 2014 (no date documented) Resident #55 weighed 144.7 pounds, weighed 141.4 pounds in January 2015, and weighed 138.9 pounds in February 2015. A 02/09/15 nutritional progress note, written by the facility's RD, documented Resident #55 was working with speech therapy and was picking up	F 325	1. The Administrator immediately got a sandwich for Resident #55. The dietary staff were inserviced on 4-30-15 regarding the importance of putting a sandwich on the tray of Resident #55 at each meal. 2. The Dietary staff will be inserviced on 5-22-15 regarding the importance of following tray cards appropriately. The nursing staff will be inserviced between May 18th thru May 31st on how to read the tray card and regarding the importance of checking tray cards at each meal to assure that the items on the tray match the tray cards. A list of residents with weight loss or that their weight is trending downward was generated to assure that there were dietary interventions in place. 3. Audits will be completed to assure that all dietary interventions provided with meals are in place to prevent weight loss. These audits will be conducted on 10	

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F 325	Continued From page 7 and eating banana/mayonnaise sandwiches. The RD recommended discontinuing the resident's med pass nutritional supplement due to refusals to drink it, and this was carried out per physician order. A 02/09/15 speech therapy note documented, "Patient seen at lunch and interestingly enough w/o (without) being asked patient verbally requested some sandwiches as an alternate. Assisted patient in using template cutter stamp to divide sandwiches into small bite sized portions." The resident's Monthly Record of Vital Signs and Weights documented in March 2015 (no date documented) Resident #55 weighed 135.7 pounds. A 03/20/15 nutritional progress note, written by the facility's RD, documented Resident #55 was continuing to lose weight. "Resident nods head that he likes sandwiches....Resident states he will eat sandwiches and discussed with speech therapy--dietary informed and added to tray card." The resident's Monthly Record of Vital Signs and Weights documented in April 2015 (no date documented) Resident #55 weighed 133.9 pounds. A 04/02/15 nutritional progress note, written by the facility's RD, documented Resident #55 was receiving sandwiches with all meals. A 04/02/15 quarterly minimum data set (MDS) documented the resident's cognition of moderately impaired, he required set up help only with meals, he had experienced no significant weight loss or gain, and he was on a	F 325	residents weekly x 4 then monthly x 2. Any deficient areas will be corrected immediately. 4. The results of these audits will be taken to the facility QA&A committee. Recommendations will be made based on the findings of these audits.	

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F 325	Continued From page 8 mechanically altered diet. The resident's care plan, last updated on 04/03/15, identified "Resident is at risk for complications due to history of chewing and swallowing issues" as a problem. Interventions to this problem included speech therapy as needed, diet modifications as ordered, and safe swallowing strategies. At 5:40 PM on 04/28/15 Resident #55 was eating his supper meal in his room. The resident's tray slip documented he was to receive a sandwich at meals, but there was no sandwich on his meal tray. At 8:47 AM on 04/29/15 Resident #55 was eating his breakfast meal in his room. The resident's tray slip documented he was to receive a sandwich at meals, but there was no sandwich on his meal tray. At 12:10 PM on 04/29/15 the kitchen trayline operation was observed. A caller called out the diet for each resident and other pertinent information such as adaptive utensils, likes/dislikes, and supplements. A second employee placed beverages and condiments on the meal trays. The cook placed the food on the plates, and the caller verified the food being sent matched the tray slips before placing the trays in the carts. At 6:00 PM on 04/29/15 Resident #55 was eating his supper meal in his room. The resident's tray slip documented he was to receive a sandwich at meals, but there was no sandwich on his meal tray.	F 325		

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F 325	Continued From page 9 At 6:07 PM on 04/29/15 nursing assistant (NA) #3 stated as he set up resident meal trays he checked tray slips to make sure residents received the correct diet and consistency, supplements, and likes and dislikes were honored. At 6:12 PM on 04/29/15 the administrator stated the kitchen would be bringing the resident a sandwich. At 6:25 PM on 04/29/15 a whole bologna and cheese sandwich, which was tightly wrapped in plastic wrap, was on Resident #55's meal tray. The resident nodded that he would appreciate a staff member unwrapping the sandwich and cutting it up. At 9:07 AM on 04/30/15 NA #2 stated NAs were supposed to check the trays against the meal slips to make sure residents received the right diet, received their supplements, and their likes and dislikes were honored. At 10:12 AM on 04/30/15 the RD stated she put the intervention of sandwiches at all meals in place for Resident #55 because he was experiencing gradual weight loss, the resident identified sandwiches as a food he liked, and the sandwiches fit into the resident's diet prescription of finger foods. However, she stated she expected the staff to cut up the sandwiches for the resident so he could pick them up easier. At 10:15 AM on 04/30/15 the speech therapist (ST) stated Resident #55 seemed to enjoy eating sandwiches, but they should be cut up smaller than in quarters for improved intake and safety in chewing and swallowing.	F 325		

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