| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345177 | A. BUILDING ______ B. WING ______ | C 12/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MANOR CARE HEALTH SVCS PINEHURST | 205 RATTLESNAKE TRAIL PINEHURST, NC 28374 |

| (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 |
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| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interviews, and medical record review, the facility failed to provide showers/baths as scheduled for a resident who required assistance with bathing for 1 of 3 residents (Resident #1) reviewed for Activities of Daily Living (ADLs). The findings included:<br><br>Resident #1 was admitted to the facility on 9/30/16 with multiple diagnoses that included Diabetes Mellitus Type II. The nursing admission assessment dated 9/30/16 indicated Resident #1 required assistance with bathing.<br><br>Resident #1's admission Minimum Data Set (MDS) assessment dated 10/11/6 indicated she was cognitively intact. She was assessed as not steady with balance and only able to stabilize with staff assistance. Resident #1 had no behaviors or rejection of care. The Care Area Assessment (CAA) for ADLs indicated Resident #1 was alert and oriented, non-ambulatory, had not exhibited any moods/behaviors that interfered with care, and staff were to assist her as needed with bathing while encouraging her to do what she was able to do for herself with their support.<br><br>The plan of care for Resident #1 was reviewed. Resident #1 had a plan of care with a start date of 9/30/16 for the focus area of Activities of Daily Living (ADLs) self-care deficit as evidenced by the need for care assistance related Diabetes | F 312 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.<br><br>F 312<br><br>It is the practice of this facility to promote care for residents who are unable to carry out activities of daily living to receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>Criteria 1<br><br>Resident #1 is being provided her shower as scheduled. | 1/17/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed Donald Brown
TITLE: LNHA
(X6) DATE: 1-6-17

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 312 | Continued From page 1<br>Mellitus, Gastroesophageal Reflux Disease (GERD), hypothyroidism, and back pain. The goal was for Resident #1 to be clean, dressed, and well-groomed daily to promote dignity and psychosocial wellbeing. The interventions included, in part, assist to bathe/shower as needed.<br><br>A review of the medical record documentation for showers/baths for Resident #1 indicated her shower/bath days were Monday and Thursdays during the day shift (7:00 AM to 3:00 PM). The shower/bath documentation for Resident #1 from 9/30/16 through 12/18/16 was reviewed. Resident #1 had received 12 of 22 scheduled showers/baths. The remaining 10 scheduled showers/baths for Resident #1 had no documentation in the medical record that indicated the showers/baths had been provided (10/6, 10/13, 10/17, 10/20, 11/3, 11/10, 11/21, 11/28, 12/8 and 12/15). Resident #1 had no noted refusals of showers/baths.<br><br>An interview was conducted with Nursing Assistant (NA) #1 on 12/19/16 at 1:55 PM. She indicated showers/baths were documented in the Electronic Medical Record (EMR). She stated if a resident refused a shower/bath that it was required to be documented in the EMR and the nurse was to be informed verbally of the refusal. NA #1 stated she was familiar with Resident #1. She indicated she was not aware of Resident #1 refusing any shower/bath.<br><br>An interview was conducted with the Nurse Unit Manager (UM) on 12/19/16 at 2:55 PM. She indicated NAs documented showers/baths in the EMR. She reported NAs were also required to document refusals in the EMR and to verbally | F 312 | Criteria 2<br><br>The medical record of current residents of the facility were reviewed by the Director of Nursing to validate that there was a routine shower schedule and a PRN (as needed) shower for them in the electronic record. Review was completed on 1/6/17. PRN showers were added to the resident's task list as needed.<br><br>Criteria 3<br><br>The Director of Nursing/Unit Managers initiated education on 12/20/16 to the licensed and certified staff including weekend and PRN staff regarding shower schedules and completion of related ADL (activities of daily living) documentation. Education will be completed by 1/15/17. | |

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| F 312 | Continued From page 2<br>inform the nurse on duty. The shower/bath documentation for Resident #1 from 9/30/16 through 12/18/16 that indicated she had received only 12 of 22 scheduled showers/baths was reviewed was the Nurse UM. The Nurse UM revealed she was unable to explain why 10 of the 22 scheduled showers/baths had no documentation that indicated the shower/bath had been provided to Resident #1.<br><br>An interview was conducted with Resident #1 on 12/20/16 at 8:40 AM. Resident #1 indicated she was unable to shower independently. She reported her showers/baths were scheduled for twice per week. She stated her shower/bath days were Monday and Thursdays. Resident #1 revealed there were multiple times she had not received her shower/bath as scheduled. She stated staff had informed her that they were unable to assist her with her shower/bath as scheduled because they didn't have time. She indicated this had occurred on more than one occasion with more than one staff member. Resident #1 was unable to report the names of any specific staff members or any specific dates when she had not received her shower/bath as scheduled. Resident #1 additionally revealed it was very important to her to have a shower/bath at least twice per week.<br><br>An interview with NA #2 on 12/20/16 at 11:14 AM. She indicated NAs documented showers/baths in the EMR. She reported NAs were also required to document refusals in the EMR and to verbally inform the nurse on duty. NA #2 stated she was familiar with Resident #1. She indicated she was not aware of Resident #1 refusing any shower/bath. The shower/bath documentation for Resident #1 from 9/30/16 through 12/18/16 that | F 312 | Criteria 4<br><br>The Director of Nursing/Unit Managers will complete random weekly audits of 5 residents from both units weekly for one month and then 5 residents from both units monthly for 2 months to ensure compliance with shower schedules and ADL documentation.<br>The Administrator will review the results of the audits and submit results to the QAPI committee for further recommendations as appropriate. | |

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| F 312 | Continued From page 3<br>indicated she had received only 12 of 22 scheduled showers/baths was reviewed with NA #2. NA #2 revealed that there had been times when she was not able to complete all of her assigned residents' showers/baths during her shift due to time constraints. NA #2 stated that if she was unable to provide a resident's shower/bath as scheduled that she reported this information verbally to the nurse on duty as well as to the NA that was coming on duty.<br><br>A second interview with NA #2 was conducted on 12/20/16 at 11:30 AM. She stated she forgot to mention that occasionally she may have provided a resident's shower/bath and had not documented it in the EMR due to time constraints.<br><br>An interview was conducted with NA #3 on 12/20/16 at 11:37 AM. She indicated NAs documented showers/baths in the EMR. She reported NAs were also required to document refusals in the EMR and to verbally inform the nurse on duty. NA #3 revealed that there had been times when she was not able to complete all of her assigned residents' showers/baths during her shift due to time constraints. She reported that if she was unable to provide a resident's shower/bath as scheduled that she gave the resident a bed bath. She indicated a bed bath took less time than a full shower/bath. NA #3 stated a bed bath was also required to be documented in the EMR.<br><br>An interview was conducted with the Director of Nursing (DON) on 12/20/16 at 11:50 AM. She stated shower/bath documentation was completed in the EMR by NAs. She indicated her expectation was for showers/baths to be provided | F 312 | | |

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| F 312 | Continued From page 4<br>as scheduled. She indicated if an NA was unable to complete the scheduled shower/bath during their shift that they were expected to inform the nurse on duty as well as the NA coming on shift. She indicated if the NA coming on shift was unable to provide the shower/bath during their shift, then the NA that had originally been assigned the resident's shower/bath was expected to provide the shower/bath to that resident on the next scheduled shift they worked. The DON stated if a shower/bath had been provided, it should have been documented in the EMR. She stated if a bed bath had been provided on a scheduled shower/bath day that it should have been documented in the EMR. She additionally stated if a shower/bath had been refused, it should have been documented in the EMR. The shower/bath documentation for Resident #1 from 9/30/16 through 12/18/16 that indicated she had received only 12 of 22 scheduled showers/baths was reviewed was the DON. The DON revealed she was unable to explain why 10 of the 22 scheduled showers/baths had no documentation in the EMR that indicated it had been provided as scheduled. The DON reported she had looked over the shower/bath documentation for Resident #1 on 12/19/16 when it was initially requested for review. She stated the shower/bath documentation for Resident #1 was a surprise to her and she had not known why they had not been provided as scheduled.<br><br>A second interview was conducted with the DON on 12/20/16 at 12:19 PM. She stated that in addition to the EMR shower/bath documentation there were hard copy "shower/bath sheets" that NAs turned in to the nurse on duty following the completion of their shift. She stated that if the | F 312 | | |

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| F 312 | Continued From page 5<br>NA had turned in the shower/bath sheet that it meant the shower/bath had been given. She stated the hard copy sheets were not part of the resident's medical record. She reported her expectation was for the EMR documentation to be completed as well as the hard copy shower/bath sheets. | F 312 | | |
| F 353 SS=D | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br>[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(a) Sufficient Staff.<br>(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not | F 353 | F 353<br><br>It is the practice of this facility to promote care for residents by having sufficient nursing staff to insure resident safety and attain or maintain the highest practiceable physical, mental, and psychosocial well-being for each resident.<br><br>Criteria 1<br><br>Resident #1 is being provided her shower as scheduled.<br><br>Criteria 2<br><br>Current residents of the facility were reviewed by the Director of Nursing to validate that there was a shower schedule and a PRN shower for them in the electronic record. Documentation will be reviewed by the Director of Nursing/Unit Managers to determine adherence of shower schedule by 1/15/17. | 1/17/17 |

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Continued From page 6

limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to have sufficient nursing staff to provide showers/baths as scheduled for a resident who required assistance with bathing for 1 of 3 residents (Resident #1) reviewed for Activities of Daily Living (ADLs). The findings included:

This tag is cross referred to:

F312: Based on resident interview, staff interviews, and medical record review, the facility failed to provide showers/baths as scheduled for a resident who required assistance with bathing for 1 of 3 residents (Resident #1) reviewed for Activities of Daily Living (ADLs).

An interview was conducted with Nursing Assistant (NA) #2 on 12/20/16 at 11:14 AM. She indicated her assigned residents varied from day

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Criteria 3

Daily staffing meetings are conducted with the Administrator, Director of Nursing, Human Resources Director, and the scheduler to ensure adequate levels of nursing staff are available to meet patient needs at all times. The daily and weekly schedules are reviewed and adjusted as needed.

Criteria 4

The Administrator or Director of Nursing will complete 5 resident interviews a week to determine satisfaction with level of assistance with ADLs weekly for four weeks and then monthly for two months. The Administrator will review the results for trends and will report all findings to the QAPI committee for further recommendations as appropriate.

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| F 353 | Continued From page 7<br>to day. She reported that her resident assignment was generally between 10 and 16 residents. She revealed there had been times when she was not able to complete all of her duties during her scheduled shift.<br><br>An interview was conducted with NA #3 on 12/20/16 at 11:37 AM. She indicated the facility was "always short" on NAs. She revealed she hardly ever had to time to get all of her assignments completed within her scheduled shift. She reported she had spoken with the Director of Nursing (DON) in the past about her concerns and she had tried to help, but it had not gotten any better.<br><br>An interview was conducted with the DON on 12/20/16 at 11:50 AM. She stated that the facility had been "short" on NAs lately. She stated her ideal staff ratio was 10 to 12 residents per NA. She revealed the facility had difficulty maintaining NAs. She reported they recently had lost some employees due to the competitive wages offered at local facilities. She additionally reported they had a few staff on medical leave. The DON indicated the facility was in the process of hiring NAs and they were also working with their corporate office on strategies for maintaining NAs.<br><br>An interview was conducted with the Facility Scheduler on 12/20/16 at 12:30 pm. She indicated the facility was not at full staff for NAs. She reported she began working at the facility in September 2016 and since that time the facility had been constantly working to obtain full staff for NAs. She reported the facility was hiring NAs, but there was a major turnover rate. She explained that the facility hired 5 new NAs and maybe 1 of | F 353 | | |

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| F 353 | Continued From page 8<br>them stayed long term. She indicated when she first began working at the facility she scheduled 9 NAs on the first shift (7:00 AM to 3:00 PM), 8 NAs on the second shift (3:00 PM to 11:00PM), and 4 NAs on the third shift (11:00 PM to 7:00 AM). She reported that about a month ago the facility changed staffing numbers to 10 NAs on the first shift, 9 NAs on the second shift, and 5 NAs on the third shift. She explained that the change was made because there was a high number of call offs and scheduling the additional NA on each shift was in anticipation of someone calling off. The Facility Scheduler stated she often had difficulty finding staff to fill in each slot on the schedule. She reported she had to try to get staff to come in early, staff to stay late, and staff to come in on their days off. She revealed sometimes she was unable to find an NA to fill all of the slots on the schedule. She additionally revealed the facility was currently down 4 NAs on the first shift and 3 NAs on the second shift. She stated the third shift was presently at full staff for NAs. The Facility Scheduler indicated the administrative staff were always talking about ways to hire and maintain NAs, but it continued to be an ongoing problem. | F 353 | | |
| F 465 SS=D | 483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON<br><br>(h) Other Environmental Conditions<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>(h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and | F 465 | F 465<br><br>It is the practice of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. | 1/17/17 |

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| F 465 | Continued From page 9<br>regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to keep the kitchen floor in good condition as evidenced by broken tiles observed in the dish washing area and failed to maintain the dish washing machine in clean condition.<br>The findings included:<br>1. On 12/20/16 at 8:10AM, a tour of the kitchen was conducted with the Dietary manager. There were three areas in the dishwasher area that had several broken tiles. There were two rubber mats over the broken tile areas. One of the areas that did not have tiles had a cement patch in that area (where the dishes were left drying). There was an area in front of the dish machine and the sink area that had broken tiles and had an area that was "soft" when the area was stepped on by staff. This area was covered with an open rubber mat. Dietary staff #1 stated the tiles had been broken for about two years. She said the water would come up around the tile area. The dietary manager said they kept the mats over the broken tile areas and hoped they would get replaced when the painting was done.<br>On 12/20/16 at 9:10AM, a tour of the kitchen was completed with the Maintenance supervisor. He stated he was going to have the kitchen area painted next week (contractor). He also stated he was aware of the broken tiles and he was going to do the repair himself next week also. He said he had not received a written requisition for the tiles.<br>A review of the maintenance logs from September 20th through present was reviewed. There were not entries about the broken tiles or | F 465 | Criteria 1<br><br>The 3 areas of broken tile and the metal guard were repaired/removed on 12/20/16 by the facility maintenance director. The dish machine was cleaned by the dietary manager on 12/20/16.<br><br>Criteria 2<br><br>A kitchen environmental round was completed on 12/20/16 by the Administrator, maintenance director, and the dietary manager. The Environmental round resulted in no other areas being identified as deficient. | |

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

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| F 465 | Continued From page 10<br>that the floor in the kitchen needed to be repaired. The Maintenance supervisor stated he only kept the logs at each nursing station and did not have any other maintenance logs that pertained to the kitchen.<br>On 12/20/16 at 10:00AM, an interview was conducted with the Maintenance supervisor. The Maintenance supervisor stated he did not write down everything that needed repair such as the tiles in the kitchen and things got repaired depending on how quick he could get to it. The Administrator stated they hoped to get the tile floor repaired soon.<br>On 12/20/16 at 11:40AM, an interview was conducted with the Maintenance supervisor. He stated there was no formal policy/ procedure for notification to maintenance for needed repairs. He stated he was the only person in maintenance and is on call 24/7. He said the housekeeping supervisor did the maintenance when he was on vacation. The Maintenance supervisor said there were maintenance books at each nursing station (two nursing stations) for all departments to use for needed repairs. He said he checked the books each morning and several times during the day. Regarding the tiles in the kitchen, he said he had repaired the tiles previously but the repair did not work and he had just not had time to get to repairing them again.<br>2. On 12/20/16 at 8:10AM, a tour of the kitchen was conducted with the Dietary manager. An observation of the dish machine revealed a large amount of food particles and brown material was noted on each side of the dish machine and on the front of the dish machine. There was also a metal guard that had been removed from the side of the dish machine. It was lying on the left side of the dish machine and had a large amount of food particles and brown material on the surface | F 465 | Criteria 3<br><br>The cleaning schedule was updated by the dietary manager to include the dish machine and the areas around the dish machine. These areas are scheduled to be cleaned daily with a weekly deep clean. The revised cleaning schedule education for the dietary staff was initiated on 12/28/16 by the dietary manager. All education will be completed by 1/15/17. The maintenance request log has been placed in the kitchen for repairs that may need to be completed.<br>Education to the maintenance supervisor and the dietary staff was initiated on 12/30/16 by the Administrator regarding the maintenance request log and the process for checking the log. Education will be completed by 1/15/17. In the absence of the maintenance supervisor, the Administrator or the housekeeping supervisor will check the maintenance request log. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345177 | A. BUILDING ______<br>B. WING ______ | C<br>12/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MANOR CARE HEALTH SVCS PINEHURST** | **205 RATTLESNAKE TRAIL**<br>**PINEHURST, NC 28374** |

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| F 465 | Continued From page 11<br>of the metal guard. There was a metal spatula on the left side of the dish machine with food particles on the spatula surface. The Dietary manager stated there was a cleaning schedule and the area was deep cleaned every other week and she expected the area to be clean.<br>A review of the weekly maintenance cleaning schedule for November and December 2016 revealed the dish machine area was not included on the cleaning schedule for November. The December cleaning schedule indicated the dish machine area was to be deep cleaned every other Thursdays and Mondays. Week 1 and 2 was blank. Week 3 indicated the area was deep cleaned on 12/14/16.<br>On 12/20/16 at 9:45AM, an interview was conducted with dietary staff #1. She stated she occasionally washed the dishes and she sprayed down the dish machine when she did the dish area. She stated she thought she washed down the area last Thursday but it was not her regular job to do the dishes.<br>On 12/20/16 at 12:17PM, an observation of the dish machine area revealed the dish machine was clean and without any food particles or brown material. The Dietary manager stated they had cleaned the area with a de-liming solution and that had cleaned the area. | F 465 | Criteria 4<br><br>The maintenance supervisor, Administrator, or dietary manager will perform two random environmental rounds in the kitchen weekly for four weeks and then monthly for two months. The dietary manager or Administrator will randomly audit the cleaning schedule logs for completion twice weekly for one month and then monthly for two months.<br>The findings of the rounds and audits will be submitted by the Administrator to the QAPI committee monthly for review and for further recommendations to ensure compliance. | |