| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345516 | A. BUILDING _____ B. WING _____ | C 08/23/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CONOVER NURSING AND REHAB CTR | 920 4TH STREET SOUTHWEST CONOVER, NC 28613 |

| (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 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(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 observations, record reviews and interviews the facility failed to assist a resident dependent who required extensive assistance with personal hygiene to 1 of 4 residents reviewed for activities of daily living (Resident #65).<br><br>The finding included:<br><br>Resident #65 was admitted to the facility on 05/13/19 with diagnoses which included hypertension and osteoarthritis.<br><br>Review of Resident #65's Quarterly Minimum Data Set (MDS) assessment dated 07/30/18 revealed she had moderately impaired cognition and required extensive assistance with most of her activities of daily living (ADLs).<br><br>Review of Resident #65's Care Area Assessment for ADLs dated 04/30/18 revealed in part that she required extensive assistance of one to two staff for most of her ADLs (which included personal hygiene).<br><br>Review of Resident #65's Care Plan dated 07/10/18 indicated the care she required exceeded the home care setting therefore her needs would be met by the facility staff on a daily basis. | F 677 | F677<br>1. The food particles were removed from Resident #65's wheel chair as soon as the nurse aides saw them. Nurse aides were counseled regarding checking residents to be sure there were no food particles in their wheelchairs after meals.<br>2. Complete rounds were completed on 8/22/18 and every resident in the facility was checked to be sure no food particles were left on wheelchairs after meals. No other residents were found to have food particles in the wheelchairs or on their person.<br>3. Inservice was completed by Staff Development Coordinator 9/5/2018 to remind all nursing staff of general care guidelines including cleaning food particles from resident's wheelchairs after meals.<br>4. Director of Nursing or designee will monitor 10 residents per week for 12 consecutive weeks to ensure that residents are free from food particles after meals. Results will be monitored by Quality Assurance Committee. | 9/14/18 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 09/11/2018 |

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 677 | Continued From page 1 | F 677 | | |

Observation on 08/20/18 at 2:21 PM noted Resident #65 sitting in her wheel chair next to her bed sleeping. On the seat of her wheel chair beside her left thigh were 2 pieces of meat (appeared to be beef) both approximately 1.5 inches (") x 0.5". Also noted was a white food debris on the tips of her three middle fingers on her right hand. A subsequent observation on 08/20/18 at 3:57 PM noted Resident #65 sleeping in the same position as stated above and the 2 pieces of meat remained on her wheel chair seat by her left thigh. Resident #65's right hand was clinched into a fist therefore, her fingertips were not observed.

Observation on 08/22/18 at 9:35 AM noted Resident #65 sitting in her wheel chair next to her bed sleeping. On the seat of her wheel chair beside her left thigh was an approximately quarter sized piece of scrambled egg. A subsequent observation at 11:07 AM noted her and the piece of scrambled egg were in the same position.

Interview with Nurse Aides (NA) #4 and #5 on 08/22/18 at 12:00 PM revealed they made rounds on the residents every two hours for general ADL care which included toileting, bathing and personal hygiene. NA #4 explained they did not have specific resident assignments because they worked together as a team to get the work done. NA #4 stated that they kept a list at the kiosk with the residents' name on it and when a round was completed they would put a check mark next to the resident's name which indicated the resident's care had been completed.

On 08/22/18 at 12:04 PM an observation was made of Resident #65 with both NAs #4 and #5

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present and both stated that Resident #65 had already been checked this morning. The resident was awake sitting in her wheel chair next to her bed and the piece of scrambled egg remained on the wheel chair seat next to her left thigh. NA #5 picked the piece of scrambled egg off of the resident's seat and stated that (the egg) should have been removed before now. Neither NA could report who had checked Resident #65 after breakfast this morning or what care had been done for her. NA #4 indicated the check sheets were not kept from day to day therefore it could not be determined which NA had checked Resident #65 after lunch on 08/20/18.

Interview with Nurse #1 on 08/22/18 at 12:08 PM revealed she expected the aides to provide personal hygiene for the residents on the first round after meals which included making sure excess food be removed from their persons.

Interview with Interim Director of Nursing (IDON) on 08/23/18 at 1:38 PM revealed she would not expect the aides to wake Resident #65 up to provide personal care but felt that removing a piece of meat or scrambled egg would not have woke her up.