


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

PRINTED: 03/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/23/2011
NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	
(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 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to determine the ability to self administer over the counter medicated cream for one (1) of one (1) sampled resident. (Resident #26).</p> <p>The findings are:</p> <p>Resident #26 was admitted to the facility on 01/26/10 with diagnoses including failure to thrive, hypertension, depressive disorder, hypothyroidism and chronic shoulder and eye pain. The most recent Minimum Data Set (MDS), an annual dated 12/15/10, coded her with severe cognitive impairment, vision and hearing loss and requiring extensive assistance with most activities of daily living skills. The Care Area Assessment dated 12/20/10 which addressed cognition described Resident #26 as being alert and oriented to self with long and short term memory impairment and independent for short distances via a wheelchair.</p> <p>During initial tour on 02/21/11 at 8:12 AM, Resident #26 was observed in bed. On her dresser was a small plastic tray with a tube of toothpaste and a tube of aspercreme (a medicated cream for pain). Directly next to these tubes was a toothbrush holder containing two</p>	F 176	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <div style="text-align: center;">  </div> <p>F 176</p> <p>The Aspercreme was removed from the resident's room. The resident's son was spoken to regarding bringing over-the-counter drugs into the facility for his mother.</p> <p>Facility rounds were conducted to insure that no other residents have medications in their room, unless they have been assessed and are appropriate for self-medicating.</p> <p>Facility Staff have been re-inserviced on the Self Administration of Medication Policy.</p> <p>Observation for medications in resident rooms has been added to the Quality Rounds conducted by Administrative staff. Results of this monitoring will be shared with the Administrator weekly and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

[Signature] Ty Lewis, NHA

[Signature] Administrator

3/17/11

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 176	<p>Continued From page 1</p> <p>toothbrushes. The tubes of toothpaste and aspercreme remained on the dresser, next to each other and adjacent to the toothbrushes on 02/21/11 at 12:10 PM and at 12:41 PM, on 02/22/11 at 8:16 AM, and on 02/23/11 at 8:55 AM.</p> <p>Review of the medical record revealed Resident #26 had no physician orders for Aspercreme and no assessment for self administration of any medication or treatment.</p> <p>Interview with Nurse Aide (NA) # 6 revealed she usually cared for Resident #26. NA #6 stated Resident #26 was able to access and use both the toothpaste and aspercreme as she desired. NA #6 stated she had seen Resident #26 apply the aspercreme independently and independently brush her teeth. NA #6 further stated that Resident #26 was very particular and wanted the aspercreme next to the toothpaste. According to NA #6, Resident #26 was able to tell the difference by touch as the toothpaste lid was off the tube and the aspercreme lid was large and flipped open.</p> <p>Interview with the Household Coordinator (HC) #2 on 2/23/11 at 9:27 AM revealed Resident #26 had long and short term memory impairment, was very hard of hearing and had some vision problems. HC #2 further stated on 2/23/11 at 11:20 AM that if Resident #26 knew she had the aspercreme she would know what to do with it. HC #2 stated nursing determined resident abilities to self medicate.</p> <p>Interview with Licensed Nurse (LN) #9 on 2/23/11 at 11:05 AM revealed she was unaware that Resident #26 had aspercreme or that she was applying it herself. LN #9 stated she had not</p>	F 176		
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F 176	Continued From page 2 noticed the aspercreme in the resident's room. LN #9 stated that if a resident was to self medicate, the physician would have to make that determination. Interview with the Nurse Mentor (NM) #2 on 2/23/11 at 11:20 AM revealed she was unaware of Resident #26 having and/or applying aspercreme. NM #2 further stated she did not think Resident #26 should be self medicating the aspercreme.	F 176			
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278	F 278 A meeting was held with the members of the Interdisciplinary Team, to discuss the identified issues pertaining to the Resident Assessment Instrument <ul style="list-style-type: none"> • Completion of all MDS items assigned to them as required • Completion of triggered CAAs as indicated by the MDS assessment The Social Worker has been re-inserviced regarding the need to complete assessments in their entirety. The Registered Nurse who was responsible for verifying completion of the MDS is aware that she must be sure the MDS is signed when completed. The Dietary Manager has been re-inserviced to insure that Section K is complete before signing Z0400.		

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F 278	<p>Continued From page 3</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to correctly and completely assess five (5) of fourteen (14) sampled residents. Information on the Minimum Data Sets was left blank or coded incorrectly and/or the Care Area Assessments were not completed as triggered for assessments. (Residents #3, #5, #14, #15, and #20).</p> <p>The findings are:</p> <ol style="list-style-type: none"> Resident #15 was admitted to the facility on 12/20/10 with diagnoses including dysphasia, left upper extremity weakness, and history of pneumonia. <p>A review of the admission Minimum Data Set (MDS) dated 12/27/10 revealed the sections C0100 through C1000 assessing cognitive patterns and sections F0300 through F0800 assessing preferences for customary routines were left blank. Further MDS review revealed in the section assessing swallowing/nutritional status no height was listed at K0200. Continued review revealed in section Z0400 there were no signatures indicating section F was completed. The signature of the Registered Nurse verifying assessment completion was missing in section Z0500.</p> <p>An interview with the Dietary Manager (DM) on 02/23/11 at 9:25 a.m. revealed she was responsible for documenting the height in section</p>	F 278	<p>The LN #8 has been re-inserviced regarding the correct coding method of pressure ulcers for the MDS.</p> <p>The assessments for residents in the facility have been reviewed to insure that assessments are complete and that no other assessments or CAAs have been missed.</p> <p>Education has been conducted for members of the Interdisciplinary Team regarding the Minimum Data Set Process.</p> <p>An audit will be conducted by the MDS Coordinator to insure:</p> <ul style="list-style-type: none"> Resident assessments are completed and signed Indicated assessments are present for residents Triggered CAAs are present on the medical record <p>Results of this monitoring will be shared with the Administrator weekly and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11

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F 278	<p>Continued From page 4</p> <p>K0200. She stated it was her common practice to refer height to nursing to obtain when she could not locate documentation for height in a resident's admission record. She added this was the case with Resident #15. The DM stated she did not follow up with nursing to ensure the height was obtained. She continued stating her signature in section Z0400 verified K was completed and it was not.</p> <p>An interview with the Director of Nursing (DON) on 02/23/11 at 9:35 a.m. revealed she expected MDS assessments and verifications were accurately documented and completed.</p> <p>An interview with Social Worker (SW) #1 on 02/13/11 at 9:41 a.m. revealed she was responsible for the sections assessing cognitive patterns and preferences for customary routine. She stated the day she visited Resident #15 with intentions of completing the assessments, the resident was ill and did not feel up to answering questions. SW #1 stated it was her intention to complete the assessments and document them. She stated in section Z0400, she signed the section assessing Cognitive Patterns as complete and the section assessing Preferences for Customary Routine was not signed completed. SW #1 added these sections should have been completed within the appropriate time frame.</p> <p>An interview with MDS Coordinator #1 revealed a Registered Nurse should have signed in section Z0500 verifying all areas of the MDS assessment had been completed. She acknowledged the signature was missing and the areas mentioned above were not complete.</p> <p>2. Resident #14 was admitted to the facility on</p>	F 278		

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F 278	<p>Continued From page 5</p> <p>01/30/04 with diagnoses including Alzheimer's Disease, osteoporosis and hyperthyroidism.</p> <p>A review of Resident #14's Minimum Data Set (MDS), dated 11/23/2010 revealed sections B0700 and B0800 assessing the resident's ability to make self understood and ability to understand were blank. Also, sections D0100, D0500 and D0600 assessing the resident's mood were blank. Continued review revealed in section Z0400 there were no signatures indicating section D was completed. MDS Coordinator # 1 signed the document on 11/29/2010 verifying the assessment was complete.</p> <p>An interview with MDS Coordinator #1 revealed that sections B0700, B0800, D0100, D0500 and D0600 should have been completed. She further stated the Household Coordinator assigned to Resident #14's neighborhood should have interviewed staff and completed Section D0500 based on the staff's report of the resident's mood. She verified that the signature of the MDS Coordinator in section Z0500 indicated the assessment was complete. She further stated that it had only recently, within the last two to three weeks, been brought to her attention that the computer system was not "flagging for incomplete sections." She stated that since this was discovered she was manually reviewing all MDS assessments for completion.</p> <p>3. Review of Resident #3's record revealed a readmission date of 09/15/10 with diagnoses which included a Stage IV Pressure Ulcer. The admission Minimum Data Set (MDS) dated 09/22/10 coded the Pressure Ulcer as Stage IV. Review of the most recent quarterly Minimum Data Set dated 02/2/11 revealed Resident #3's</p>	F 278		

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F 278	<p>Continued From page 6 pressure ulcer was coded a Stage III.</p> <p>Review of the weekly Wound Tracking Reports from 12/4/10 to 02/16/11 revealed the sacral pressure ulcer was documented as a Stage IV. The ulcer's documented dimensions were 6.0 cm by 5.0 cm and 2.0 with tunneling at 12:00 PM on 02/16/11.</p> <p>Interview with Licensed Nurse (LN) #8 at 1:05 PM on 02/22/11 revealed she coded the pressure ulcer a Stage III because the ulcer improved. She explained she thought the MDS required a stage change when improvement occurred. LN #8 reported she used the wound tracking reports and her assessments to code pressure ulcers.</p> <p>Interview with MDS Coordinator #1, at 1:10 PM on 02/22/11 revealed she relied on LN #8 to enter the correct information on the MDS. MDS Coordinator #1 reported she was not aware of the change from Stage IV to Stage III on the MDS.</p> <p>4. Review of Resident #20's record revealed an admission date of 11/12/10. The admission Minimum Data Set (MDS) dated 11/19/10 revealed staff reported daily mood symptoms (tiredness and poor appetite) and noted a preference for group activities. The Care Area Assessment (CAA) Summary dated 11/24/10 noted the triggered care areas of Psychosocial Well-Being and Activities were documented by Social Worker (SW) #1 to be located in the psychosocial assessment.</p> <p>Review of Resident #20's record revealed there was no documentation of a psychosocial assessment available for review.</p>	F 278		
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F 278	<p>Continued From page 7</p> <p>Interview with Nursing Assistant (NA) #5 at 11:15 AM on 02/23/11 revealed Resident #20 came to meals in the dining room and watched television in his room. She reported a family member came everyday to visit.</p> <p>Interview with Social Worker (SW) #1 at 11:20 AM on 02/23/11 revealed she could not locate Resident #20's psychological assessment. She reported she completed an assessment and did not keep a copy.</p> <p>Interview with MDS Coordinator #2 at 11:30 AM on 02/23/11 revealed she distributed the CAA assessment forms to the appropriate departments for completion. MDS Coordinator #2 explained the assessments were placed in the record by the person who completed the assessment. She reported this system was soon to change to enable her to receive the completed form.</p> <p>5. Resident #5 was readmitted to the facility on 01/29/08. Diagnoses included congestive heart failure, Alzheimer's disease, history of falls and history of hip fracture.</p> <p>According to the quarterly Minimum Data Set (MDS) dated 09/02/10, Resident #5 was nonambulatory and required extensive to total assistance for all activities of daily living skills (ADLs). Resident #5's annual MDS dated 11/23/10 coded her as having walked in the room and corridor once or twice in the review period with set up help only. During this review period, her balance for walking was coded as activity not occurring. There was no ADL Care Area Assessment completed.</p>	F 278		

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F 278	Continued From page 8 The current care plan last updated 2/21/11 addressed Resident #5's need for total assistance with ADLs with the goal that her daily needs would be anticipated and met daily. Interventions included that a total lift for all transfers would be used. Resident #5 was not observed out of bed through out the survey. Interview with Nurse Aide (NA) #6 on 02/22/11 at 9:18 AM revealed Resident #5 does not ambulate, does not move around on her own in bed, and is rarely transferred out of bed anymore.	F 278		
F 281 SS=D	Interview on 02/23/11 at 8:40 AM with MDS Coordinator #1 revealed the coding of the MDS for Resident #5 was taken off the caretracker which is imputed by the nurse aides. MDS coordinator #1 stated that Resident #5 was unable to ambulate and that this coding was incorrect as Resident #5 cannot ambulate. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, policy review, record reviews, and staff interviews, the facility intended to administer a medication before correctly obtaining an apical pulse as ordered by the physician for one (1) of six (6) sampled residents. (Resident #25). The facility also failed to follow a physician's order to obtain a laboratory	F 281		

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F 281	<p>Continued From page 9</p> <p>value for one (1) of fourteen (14) sampled residents. (Resident #9).</p> <p>The findings are:</p> <p>1. An excerpt from an unnamed and undated resource provided by the facility defined apical pulse as the pulse that is located on the left side of the chest slightly below the left nipple and is taken with a stethoscope.</p> <p>Resident #25 was readmitted to the facility 08/20/08 with diagnosis including venous insufficiency and hypertension.</p> <p>A review of Resident #25's medical record revealed a current physician's order for Metoprolol 25 milligrams one half tablet by mouth twice a day. The order continued with instructions to hold for apical pulse less than 60.</p> <p>An observation during medication administration on 02/22/11 at 9:00 a.m. revealed Licensed Nurse (LN) #5 obtained a pulse reading on Resident #25 utilizing a pulse oximeter on the resident's right middle finger. LN #5 was observed assessing the radial pulse rate by placing two fingers on the resident's right wrist. Continued observation revealed LN #5 prepared the Metoprolol for administration.</p> <p>An interview with LN #5 on 02/22/11 at 9:05 a.m. revealed it is her common practice to utilized the pulse oxlmeter to assess the apical pulse rate. She continued stating she rechecks the accuracy of the pulse oximeter by checking the pulse rate manually at the wrist. Additional interview revealed LN #5 was unaware checking the pulse rate via pulse oximeter on a finger and at the wrist</p>	F 281	<p>F 281</p> <p>1 LN #5 was immediately re-inserviced on the procedure for obtaining an apical pulse.</p> <p>A review of the MARs has been conducted to identify those residents for whom medication administration is dependent on vital sign parameters.</p> <p>Licensed Nurses have been re-inserviced regarding the procedure for taking the apical pulse.</p> <p>The Pharmacy Consultant will conduct medication administration observations. Results of these observations will be shared with the Director of Nursing as they occur and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11	

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F 281	<p>Continued From page 10 was not an apical pulse rate.</p> <p>An interview with Neighborhood Mentor (NM) #3 on 02/22/11 at 1:10 p.m. revealed she expected apical pulses to be assessed with a stethoscope over the heart. She added pulses assessed at the wrist or bend of the arm were not apical pulses.</p> <p>2. The facility's policy "Processing Lab Orders" last reviewed/revised 11/04 included procedures: *complete lab requisition; *write ordered lab on unit log to track that lab is drawn and results are returned; *record the date completed and initials on the lab log (if lab test is not done, notify Nurse Manager or designee); *the unit secretary will forward a copy of the lab log to finance the first of the week.</p> <p>Resident #9 was readmitted to the facility on 11/02/10 with diagnoses including depression with psychosis, anxiety disorder and hallucinations.</p> <p>February 2011 physician orders included Depakote E.C. 250mg to be administered once per day. Physician Progress notes dated 02/04/11 noted that Resident #9's depression with psychosis improved and plans were to check the Depakote level. A physician's order was written on 02/04/11 for laboratory testing including a Depakote level on Monday (02/07/11) along with two other laboratory tests. Review of the medical record revealed no Depakote level result was in Resident #9's medical chart.</p> <p>The system the facility utilized for laboratory testing was reviewed with the unit secretary #1 on</p>	F 281	<p>2 The Depakote level was obtained and was within normal limits.</p> <p>The Lab Logs have been reviewed to ensure that lab tests have been completed as ordered.</p> <p>Licensed Nurses have been re-inserviced regarding the Lab Policy and Procedure.</p> <p>The Nurse Leaders/Nurse Mentors/ Weekend Supervisor will review the Lab Log on a daily basis to insure that lab tests have been performed and lab results have been received.</p> <p>The 3-11 Supervisor will on a bi-weekly basis review the Lab Logs to insure that ordered lab tests have been completed. Results of this monitoring will be shared weekly with the Director of Nursing and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11

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F 281	<p>Continued From page 11</p> <p>02/22/11 at 4:25 PM and noted that the Depakote lab was listed as needing to be drawn on 02/07/11 in the laboratory book. The laboratory slip was also checked and noted that Depakote was written as a special lab that was to be drawn on 02/07/11 with the other two tests. There was no indication in the laboratory book that any of the laboratory tests scheduled for 02/07/11 were received back even though the other two tests were in Resident #9's medical record. The unit secretary #1 then called the lab and found that there were no evidence of any Depakote level testing completed on 02/07/11. The laboratory test was rescheduled for 02/23/11. The unit secretary stated that the nurse usually checks the laboratory book and laboratory results daily.</p> <p>Interview on 02/22/11 at 4:32 PM with the Neighborhood Mentor #2 revealed that the Charge Nurse was responsible to check laboratory testing daily and mark off in the lab book when results were obtained. Review of this book revealed no labs were checked off as being received for the entire month of February.</p> <p>Interview with Charge Nurse #2 on 02/22/11 at 4:35 PM revealed that it was her responsibility to check the laboratory tests as they were returned to the facility to ensure they were completed as ordered. She stated she was supposed to mark in the lab book daily when she received the laboratory tests. Review of the lab book at this time revealed no laboratory tests were marked as received the entire month of February 2011. Charge Nurse #2 stated that she would check all physician orders and the laboratory results at the end of each month to ensure all laboratory tests were returned, before sending the laboratory log to the billing department. Charge Nurse #1</p>	F 281		

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<p>F 281</p> <p>F 309 SS=D</p>	<p>Continued From page 12 confirmed that the Depakote level was not drawn as ordered.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide required supervision as ordered by the physician during an evening meal for one (1) of six (6) sampled residents. (Resident #15).</p> <p>The findings are:</p> <p>Resident #15 was admitted to the facility 12/20/10 with diagnoses including dysphasia and left upper extremity weakness. An admission Minimum Data Set (MDS) dated 12/27/10 revealed the resident was able to express his ideas and wants, understood others, and had clear comprehension. The MDS indicated Resident #15 required assistance with transfers and hygiene and supervision with eating. A care area assessment (CAA) related to nutrition and dated 12/27/10 revealed a mechanical altered diet with thickened liquids was provided for Resident #15. Swallowing protocols were in place and the resident was able to feed himself.</p>	<p>F 281</p> <p>F 309</p>	<p>F 309</p> <p>Resident #15 is provided with supervision during meals.</p> <p>Care Guides have been reviewed to insure that appropriate resident care information is available.</p> <p>Inservice has been conducted for facility staff and for students and teachers utilizing the facility regarding:</p> <ul style="list-style-type: none"> • Reviewing the Care Guide • Supervision during meals • Swallowing/aspiration precautions <p>Extended family members will monitor the meal service on an ongoing basis to insure that proper levels of supervision are maintained..Results of this monitoring will be shared with the Director of Nursing weekly and with the facility Quality Assessment and Assurance Committee monthly.</p>	<p>3/23/11</p>
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F 309	<p>Continued From page 13</p> <p>A care plan dated 01/06/11 identified Resident #15 with altered nutritional status related to chewing and swallowing problems secondary to dysphasia. The care plan goal included no signs and symptoms of aspiration or increased swallowing difficulty through 03/31/11. Approaches included adhere to swallowing protocol, monitor for signs and symptoms of aspiration, and refer to Speech Therapy as indicated.</p> <p>A medical record review revealed a Speech Therapy progress note dated 01/17/11. The note stated upon evaluation, Resident #15 demonstrated pharyngeal pooling with liquid intake. The note continued when the chin tuck method was utilized with nectar thick liquids, penetrating events were eliminated.</p> <p>Additional medical record review revealed a physician's order dated 01/18/11 for a mechanical soft diet with nectar thick liquids. The order continued with chin tuck with liquids, continue strict aspiration precautions with full supervision.</p> <p>A care guide utilized by nursing assistants and dated 02/21/11 designated Resident #15 required a mechanical soft diet with nectar thick liquids with full supervision, strict aspiration precautions, and chin tuck. The care guide also contained a full page containing Resident #15's name with the following written instructions dated 01/18/11: Swallowing protocol/aspiration precautions, mechanical soft diet with nectar thick liquids with chin tuck, sitting upright at 90 degrees, small bites/sips, and full supervision.</p> <p>An observation on 02/21/11 at 5:37 p.m. revealed Resident #15 was eating from a meal tray in his</p>	F 309		

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F 309	Continued From page 14 room with Licensed Nurse (LN) #10 and Nursing Assistant (NA) #4 present in the room. At 5:43 p.m. and 5:45 p.m. Resident #15 was observed unattended in his room sitting on the side of his bed eating his meal. At 5:50 p.m. the Dietary Manager entered Resident #15's room with the surveyor. At this time, the resident was observed alone in his room and sitting up in his bed. He indicated he was finished with his supper tray. An interview with NA #4 on 02/21/11 at 5:53 p.m. revealed she understood Resident #15 required the presence of a staff member in his room during meal time. She stated a nursing student took the supper tray to his room and should have known to stay with him. NA #4 stated her room assignment for the evening included Resident #15's room. An interview with the Director of Nursing on 02/22/11 at 10:53 a.m. revealed she expected staff to be in direct attendance and monitor Resident #15 as he ate his meals. An interview with the Speech Therapist (ST) on 02/23/11 at 11:40 a.m. revealed Resident #15 required supervision with all meals. She added the resident required cueing to perform chin tucks to promote safety while swallowing liquids.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if	F 322		

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F 322	<p>Continued From page 15 possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to elevate the head of the bed for one (1) of two (2) sampled residents with continuous gastrostomy tube feedings. (Resident #3).</p> <p>The findings are:</p> <p>Review of the facility's procedure for care of continuous tube fed residents which referenced Lippincott Manual of Nursing Practice (9th Edition) revealed nursing interventions to prevent aspiration included continuous head of bed elevation. The degree of head of bed elevation was not specified.</p> <p>Review of Resident #3's record revealed a readmission date of 9/15/10 with diagnoses which included Dysphagia and placement of gastrostomy tube during the hospital stay of 9/8/10 to 9/15/10. The care plan dated 02/9/11 listed aspiration precautions of monitoring for congestion, cough, increased temp and/or change in mental status. Review of the resident care guide provided for Nursing Assistants directed the head of Resident #3's bed to be "up 40% at all times."</p> <p>Physician's orders dated 02/15/11 included Resident #3 receive continuous tube feeding at a rate of 40 ml/hr.</p> <p>Observation at 2:50 PM and at 3:40 PM on 02/21/11 revealed Resident #3 in bed with the</p>	F 322	<p>F 322</p> <p>The head of the bed for resident #3 is maintained in an elevated position.</p> <p>Care Guides for tube fed residents have been reviewed to insure that accurate information is available. Rounds have been conducted to insure that the head of the bed for tube fed residents is elevated.</p> <p>Facility staff have been re-inserviced regarding the need for tube fed residents to have the head of the bed elevated.</p> <p>The monitoring of the elevation of the head of the bed for tube fed residents has been added to the Quality Rounds that are conducted by Administrative staff. Results of this monitoring will be shared with the Administrator weekly and with the facility Quality Assessment and Assurance Committee weekly.</p>	3/23/11

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F 322	<p>Continued From page 16</p> <p>head of the bed elevated at approximately 10 degrees with a continuous feeding via pump. There were no staff members in the room.</p> <p>Observation at 4:00 PM on 02/21/11 revealed Resident #3 was in bed with the head of the bed elevated approximately 10 degrees with a continuous feeding via pump. Nursing Assistant (NA) #2 lowered the head of the bed to a flat position and provided incontinence care. The feeding continued via pump. After incontinence care completion at 4:25 PM, NA #2 left the room and did not elevate the head of the bed.</p> <p>Interview with NA #2 at 4:30 PM on 02/21/11 revealed she was not aware Resident #3's head of the bed required elevation. NA #2 reported she was not aware the resident care guide provided these directions.</p> <p>Observation at 5:05 PM on 02/21/11 revealed Resident #3's bed was in the flat position with a continuous feeding via pump.</p> <p>Interview with Licensed Nurse (LN) #2 at 5:30 PM on 02/21/11 revealed tube fed residents should have the head of the bed elevated to a minimum of a 30 degree angle. LN #2 explained she "sometimes" found the head of the bed not properly elevated on her rounds. She could not estimate how frequently this occurred. Upon observation of Resident #3 at 5:33 PM on 02/21/11, LN #2 elevated the head of the bed to a 30 degree angle. LN #2 reported the head of the bed had not been elevated to the required height.</p> <p>Interview with the Director of Nursing at 8:50 AM on 02/23/11 revealed she expected head of bed elevation for residents with continuous tube</p>	F 322		

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F 322 F 371 SS=F	<p>Continued From page 17 feedings.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure opened food items were labeled with an open date, expired foods were discarded and not available for use and foods were sealed after opening. The facility also failed to ensure that the main kitchen equipment was clean and free of food splatters and grease accumulation and homemakers in the facility's neighborhood kitchens sanitized thermometers before checking food temperatures.</p> <p>The findings are:</p> <p>The facility's policy for Food Storage and Labeling dated 9/09 included: *All food not in the original container/packaging must be labeled and dated. *All food in original container must be dated with date opened. *Food stored in refrigerator should not be kept longer than expiration date. *Use bright orange labels to identify what food</p>	F 322 F 371		

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F 371	<p>Continued From page 18</p> <p>item is, current date/date of production and expiration date. Expiration date is 72 hours past current date.</p> <p>1. Observations of the facility's main kitchen on 02/21/2011 from 8:05 AM to 8:55 AM revealed the following problems with food storage in kitchen refrigerators:</p> <p>a. A container, with approximately a half gallon of applesauce in it, with an expiration date of 02/17/2011.</p> <p>b. A container, with approximately three cups of "power pudding" (a pureed combination of prunes, applesauce and bran) in it, with an expiration date of 02/17/2011.</p> <p>c. A container, with approximately one quart prunes in it, with an expiration date of 02/17/2011.</p> <p>d. A large stock pot, with approximately three gallons tomato soup, with an expiration date of 02/18/2011.</p> <p>e. An opened container of Beef Base did not have a label indicating the date it was opened.</p> <p>f. An opened container of Chicken Base did not have a label indicating the date it was opened.</p> <p>g. An opened container of Bacon Base did not have a label indicating the date it was opened.</p> <p>Interview with the Dietary Manager (DM) on 02/21/2011 at 8:15 AM revealed that leftover foods stored in refrigerators should not be stored longer than 72 hours. The DM explained that each of the leftover food items that were observed stored in the refrigerators that had exceeded expiration dates should have been discarded by staff on the date they expired. The DM also stated that the undated beef, chicken and bacon bases, which were stored in a reach-in refrigerator, should have been dated when they</p>	F 371	<p>F 371</p> <p>1. Unlabeled, opened, undated and expired items in the Main Kitchen were immediately discarded.</p> <p>The remaining food storage areas in the Main Kitchen were inspected to insure that there were no other unlabeled, opened, undated or expired items.</p> <p>Inservice for Food Service staff has been conducted regarding food safety and storage.</p> <p>A walk-through inspection of food storage areas will be conducted by the Lead Cook on a daily basis. Results of this monitoring will be shared with the Dietary Manager daily and with the Administrator and the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11

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F 371	<p>Continued From page 19</p> <p>were opened by staff. The DM explained that since the bases were not dated she could not specify when they had been opened by staff. Further interview with the DM on 02/21/2011 at 4:40 PM revealed the meat bases were good for fourteen (14) days after opening.</p> <p>2. Observation of the main kitchen's food preparation equipment on 02/21/11 at approximately 8:45 AM and on 02/22/2011 at 5:10 PM revealed the following concerns:</p> <ul style="list-style-type: none"> a. Thick black residue was observed on the vent cover for the large kettle. b. Food splatters and blackened grease was observed on the backsplash of the six-burner stove. c. Food splatters and residue was observed on the left outside of the double ovens. d. Food splatters and residue was observed on the left outside of the braisers. <p>An interview with the DM on 02/23/2011 at 8:50 AM about the cleaning schedule revealed it was implemented on 02/17/2011. The ovens were assigned to be cleaned every other week; the kettle and braisers were to be cleaned after use. She stated she knew the oven was last cleaned on 02/04/2011 because she observed a dietary employee cleaning it at that time. She was unable to offer an explanation as to why it was not cleaned on 02/18/2011 or why the outside of the oven was not cleaned. She also confirmed the vent cover for the kettle was not on the cleaning schedule and could not recall when it was last cleaned.</p> <p>3. During observation of the food delivery in the facility's Maple Knoll kitchen on 02/21/2011 at 5:30 PM, Homemaker #2 was observed to</p>	F 371	<p>2. Food preparation equipment in the Main Kitchen was immediately cleaned.</p> <p>The remaining food preparation equipment was inspected to insure that it was cleaned.</p> <p>The cleaning schedule has been revised to include all food preparation equipment on a daily/weekly basis, as appropriate. Inservice for Food Service Staff has been conducted regarding the cleaning schedule.</p> <p>The Dietary Manager will monitor the maintenance of this schedule. Results of this monitoring will be shared with the Administrator weekly and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11
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F 371	<p>Continued From page 20</p> <p>remove a food thermometer from the cabinet. Homemaker #2 wiped it with a paper towel and then began checking the temperatures of the foods which were to be served to residents during the dinner meal. Homemaker # 2 was observed to check the temperatures of each food item and did not clean the thermometer between the food items. When he finished checking the temperatures, he wiped the thermometer with a paper towel and returned it to the cabinet. An interview with the DM on 02/22/2011 at 5:10 PM revealed the homemakers in each neighborhood are expected to clean the thermometers with a sanitizing pad before checking the temperature of the first item and after each item.</p> <p>4. On 02/21/11 at 5:00 PM, prior to the tray service in the Deer Meadow kitchen, Homemaker #5 took the food temperatures with a thermometer. Homemaker #5 did not clean the thermometer once she took it from the case prior to taking food temperatures.</p> <p>On 02/23/11 at 11:55 AM prior to the tray service in the Deer Meadow kitchen, Homemaker #4 put on gloves and removed the thermometer from its case and proceeded to check food temperatures without cleaning the thermometer first. When asked about the cleaning of the thermometer, at 12:00 noon, she stated that her normal practice was to clean the thermometer prior to using it but she did not think about it today. She further stated that she was supposed to clean the thermometer prior to using it.</p> <p>An interview with the DM on 02/22/2011 at 5:10 PM revealed the homemakers in each neighborhood are expected to clean the thermometers with a sanitizing pad before</p>	F 371	<p>3&4 One to one education was immediately provided for Homemakers # 2 and # 4. They were provided with sanitizing wipes.</p> <p>Rounds were conducted in Neighborhood kitchens to insure that the other Homemakers knew the proper procedure and that sanitizing wipes were available to them.</p> <p>Inservice has been conducted for Homemakers to insure that they understand the procedure for taking the temperature of foods as well as the cleaning and storage of the thermometers.</p> <p>Random observations of Homemakers during meal service will be conducted by the Dietary Manager and Environmental Services Director to insure that procedure is followed. Results of this monitoring will be shared with the Administrator weekly and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/23/2011
NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	
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F 371	<p>Continued From page 21</p> <p>checking the temperature of the first item and after each item.</p> <p>5. During initial tour on 02/21/11 at 8:03 AM the following items were noted in the Deer Meadow Kitchen:</p> <p>A. In the refrigerator: *2 of 3 containers of tea were unlabeled and undated *Food Lion yogurt was unlabeled *Activia yogurt was unlabeled and had expiration date of 02/15/11</p> <p>B. In the freezer: *a loosely wrapped opened to air bag with one (1) pancake with no name or date; *a loosely wrapped opened to air bag with five (5) french toast slices with no name or date; *an unlabeled undated frozen container of Wendy's chill.</p> <p>C. In the upper cabinet: *a loaf of bread with an expiration dated of 01/2011. At 8:42 PM Central supply clerk #1 confirmed the bread was out of date and disposed of it.</p> <p>On 02/21/11 at 6:06 PM, Homemaker #6 stated it was her job to clean out refrigerators and cabinets daily. She further stated that she had not worked since last Thursday (02/17/11).</p> <p>On 02/21/11 at 6:08 PM Nurse Aide # 7 stated that every item brought by families and when opened should have an orange sticker, which are kept in a cabinet, marking the dated it was opened. When opened, items should be secured with plastic wrap. She further stated that when the frozen pancakes and french toast are opened, staff have not been labeling these items as they were never told to do so.</p>	F 371	<p>5. In the kitchen on Deer Meadow, the unlabeled items in the refrigerator were immediately discarded. The improperly wrapped, unlabeled and undated items in the freezer were immediately discarded. The outdated bread in the cabinet was immediately discarded.</p> <p>The kitchens in the other Neighborhoods were inspected for outdated, unlabeled or improperly wrapped foods.</p> <p>Inservice has been conducted for the Homemakers regarding Food Storage and the revised Temperature/Food Storage Log.</p> <p>During weekly rounds the Dietary Manager and Environmental Services Director will review the Temperature/Food Storage Log for compliance.</p> <p>Results of this monitoring will be shared with the Administrator weekly and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11

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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>The sheet for Resident #3 was changed.</p> <p>Adequate sheets have been provided for residents including those residents utilizing Specialty beds.</p> <p>Staff has been inserviced regarding the availability of linens and the need to change linen when soiled.</p> <p>The condition of residents linens has been added to the Quality Rounds conducted by Administrative staff. Results of this monitoring will be shared with the Administrator weekly and with the facility Quality Assessment and Assurance Committee monthly.</p>	3/23/11

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NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 19 VERHOEFF DRIVE HUNTERSVILLE, NC 28078	
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F 441	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to change a soiled bottom sheet for one (1) of three (3) sampled residents on contact precautions (Resident #3).</p> <p>The findings are:</p> <p>Review of Resident #3's record revealed a readmission date of 09/15/10 with diagnoses which included Dementia and Stage IV Pressure Ulcer. The most recent quarterly Minimum Data Set dated 02/2/11 assessed Resident #3 was always incontinent of bowel with an indwelling catheter.</p> <p>Review of Resident #3's record revealed a physician's order dated 02/9/11 for contact precautions in response to a positive stool culture for Clostridium Difficile (C. Diff.).</p> <p>Observation at 4:00 PM on 02/21/11 revealed Nursing Assistant (NA) #2 provided bowel incontinence care for Resident #3. During the incontinence care, the bottom sheet became soiled with a loose bowel movement. NA #2 wiped the bottom sheet with a wet, soapy wash cloth. NA #2 patted the wet area with a towel then covered the area with a disposable pad. She repositioned Resident #3 on the disposable pad and covered her with a clean top sheet and blanket.</p> <p>Interview with NA #2 at 4:30 PM on 02/21/11 revealed she had not replaced the bottom sheet because a clean sheet was not available. She explained Resident #3's mattress required a special sheet. NA #2 reported there was only one</p>	F 441		

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F 441	<p>Continued From page 24</p> <p>of these special sheets available. NA #2 revealed Resident #3's bowel movements were very soft or loose and frequently soiled the bottom sheet. NA #2 reported she was instructed by other nursing assistants to wipe away the bowel movement and clean the bottom sheet without removing it.</p> <p>Observation of Resident #3's room at 4:40 PM on 02/21/11 and the linen closet at 4:45 PM on 02/21/11 revealed there was no bottom sheet available for use on the therapeutic air mattress.</p> <p>Interview with Licensed Nurse (LN) #2 at 5:30 PM on 02/21/11 revealed she was not aware the bottom sheet was wiped and covered with a disposable pad. LN #2 reported a second sheet should be available.</p> <p>Observation at 9:55 AM on 02/22/11 revealed NA #1 prepared to transfer Resident #3 to the bed. There was a brown stain on the right center of the bottom sheet. There was a new bottom sheet enclosed in an unopened package in the Resident's closet.</p> <p>Interview with NA #1 at 9:56 AM on 02/22/11 revealed she had not noticed the stained bottom sheet. NA #1 explained it was a regular practice to wipe bowel movements off the bottom sheet because only one sheet was available until today. NA #1 replaced the soiled bottom sheet with the new sheet. NA #1 reported the NA staff requested a second sheet several weeks ago during a staff meeting.</p> <p>Interview with LN #4 at 10:05 AM on 02/22/11 revealed she was aware of the practice of wiping bowel movements off the bottom sheet. LN #4 reported the nursing assistants did this because</p>	F 441		

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F 441	<p>Continued From page 25</p> <p>there was only one bottom sheet available. LN #4 explained Resident #3's bowel movements were loose. LN #4 confirmed a second sheet was requested several weeks ago. She did not know the reason for delay.</p> <p>Interview with LN #3, a nurse manager, at 10:25 AM on 02/22/11 revealed a new sheet was available in the facility's central supply room. She revealed she had placed the new sheet in Resident #3's room yesterday evening. LN #3 explained Resident #3's bottom sheet was usually washed while the Resident was out of bed. LN #3 revealed she was not aware the bottom sheet was not changed when soiled. She added extra bottom sheets were available.</p> <p>Interview with the Director of Nursing at 1:20 PM on 02/22/11 revealed she expected staff to replace soiled sheets with clean sheets. She was not aware Resident #3's bottom sheet was not removed when soiled.</p>	F 441		
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Huntersville Oaks

March 21, 2011

Joy Valmassoi, SW
Facility Survey Consultant
NC Department of Health and Human Services
Division of Health Service Regulation
952 Old US Highway 70
Black Mountain, NC 28711

Dear Ms. Valmassoi

Please see the addendum below in response to the previously submitted Plan of Correction. If you have any questions, please contact me at 704.863.1083.

F176

Quality Rounds are conducted by Administrative staff once per week in all resident rooms. In addition to administrative rounds, household care giver guides (lead CNA) will round on all resident rooms in their assigned household at a minimum of once per week.

Correction Date: 3.23.11

F278

All assessments scheduled for transmission each week will be reviewed by the MDS Coordinator prior to submission.

Correction Date: 3.23.11

F281

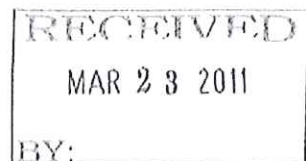
The pharmacy consultant, at a minimum will observe two medication administration passes requiring vital signs checks each month. Additionally, the nurse mentors (Unit Manager) will observe one nurse each week during medication administration requiring vital signs each week.

Correction Date: 3.23.11

F309

Extended Family Members are facility staff from all disciplines that assist w/ meal service and resident activities in their assigned households. Each extended family member will observe residents in their household who require swallowing precautions at a minimum of twice weekly to ensure proper levels of supervision are maintained.

Correction Date: 3.23.11





Huntersville Oaks

F322

Quality Rounds are conducted by Administrative staff once per week in all resident rooms. A list of all tube fed residents shall be provided to administrative staff to ensure applicable residents are monitored. Additionally, household care giver guides (lead CNA) will round on all tube fed residents in their assigned household at a minimum of once per week.

Correction Date: 3.23.11

F371

"The Dietary Manager will monitor the maintenance of this schedule."

- This statement refers to the revised cleaning schedule and the responsibility of the Dietary Manager to ensure the schedule is in place and is effective.
- The dietary manager will visually inspect all kitchen equipment on daily/weekly basis. Inspection frequency is determined/ set by the cleaning schedule.
- The Dietary Manager and the Environmental Services Supervisor will make rounds in all neighborhood kitchens at a minimum of three (3) times per week.
- Weekly rounds conducted by the Dietary Manager and the Environmental Service Supervisor will include reviewing the temperature/food storage log, and will also include looking at food storage in each neighborhood (Unit).

Correction Date: 3.23.11

F441

Quality Rounds are conducted by Administrative staff once per week in all resident rooms. During quality rounds, administrative staff will inspect linens to ensure clean linen is provided for all residents. Additionally, household care giver guides (lead CNA) will round on all residents in their assigned household at a minimum of once per week to ensure clean linen is provided.

Correction Date: 3.23.11

If you have any questions, or need additional information, please feel free to contact my office at 704.863.1023

Sincerely,

Ty Lewis, MPA, NHA
Executive Director