

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

PRINTED: 05/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2011
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NAME OF PROVIDER OR SUPPLIER REHAB AND NURSING CENTER OF MONROE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 EAST SUNSET DR MONROE, NC 28112
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F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews, and family, resident and staff interviews, the facility failed to provide a broda chair (type of bariatric wheelchair) to accommodate the residents' need to get out of bed for two (2) of four (4) sampled residents reviewed for accommodation of needs. (Resident # 28 and # 66)</p> <p>The findings are:</p> <p>1. Resident # 28 was readmitted to the facility on 08/18/09 with admitting diagnoses that included diabetès, hypertension and dementia with behaviors. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 03/30/11 revealed Resident # 28 had moderately impaired cognitive skills. The MDS further revealed Resident # 28 required total dependence with the assist of one person for locomotion.</p> <p>A review of Resident # 28's physical therapy notes dated 11/22/10 revealed a new wheelchair was ordered for the resident and she would be</p>	F 246	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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 the 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.</i></p> <p>Resident #28 and Resident #66 has an appropriate chair to allow them to be out of bed as desired.</p> <p>A one time audit was conducted on current resident population to ensure that residents have appropriate wheel chair devices to enable them to be out of bed as desired.</p> <p>The SDC will educate the nursing staff regarding the importance of resident accommodation of needs with an emphasis placed on wheel chair access and availability. This information will be included into the new employee orientation program.</p> <p>The DNS and or Unit Manager will audit five residents 2x weekly for one month then monthly for three months to ensure that residents have access to a wheel chair device as desired.</p> <p>Audit results will be analyzed and reviewed at the centers monthly Performance Improvement Committee Meeting for three months with a subsequent plan of correction as needed.</p>	5/25/2011
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

✓ Quark D. Ober ✓ ED ✓ 5/17/11

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.

MAY 19 2011

BY: _____

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F 246	<p>Continued From page 1</p> <p>assessed for seating and positioning when the new wheelchair arrived.</p> <p>A review of Resident # 28's activity attendance from January 2011 to April 2011 revealed Resident # 28 attended three to five activities a week.</p> <p>A review of Resident # 28's occupational therapy notes dated 02/17/11 revealed the therapist recommended a broda chair for long-term use. The notes further revealed the staff education on the positioning with the broda chair would increase strength and activity tolerance for Resident # 28.</p> <p>An interview with Resident # 28's family on 04/27/11 at 3:05 p.m. revealed Resident # 28 could no longer use her motorized wheelchair because it did not fit the resident properly. The family reported Resident # 28 had to use a broda chair, but she had to share the broda chair with another resident. Resident # 28 was able to use the broda chair on Tuesday, Thursday and Saturday. The family requested that the days be changed because Resident # 28 was not able to attend activities she wanted to attend on her days.</p> <p>An interview with Resident # 28 on 04/27/11 at 4:45 p.m. while she was lying in bed revealed she was able to get out of bed in the broda chair three times a week. Resident # 28 reported her days used to be Tuesday, Thursday and Saturday, and today her days changed to Monday, Wednesday and Friday in order for her to be able to attend the activities she enjoyed to attend. Resident # 28 further revealed she would get out of bed more</p>	F 246			

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F 246	<p>Continued From page 2 often if she had her own broda chair.</p> <p>An interview with Nursing Assistant (NA) # 1 on 04/28/11 at 1:35 p.m. revealed Resident # 28 could no longer use her motorized wheelchair when she fell out of her chair and she no longer fit in the wheelchair properly. NA # 1 reported Resident # 28 used a broda chair that she shared with another resident and used the chair three times a week, opposite days from when the other resident used it. NA # 1 stated Resident # 28 did get out of bed during her days when she had the broda chair and attended activities.</p> <p>An interview with Licensed Nurse (LN) # 1 on 04/28/11 at 1:43 p.m. revealed Resident # 28 was alert and oriented and she made her needs known. LN # 1 stated Resident # 28 was no longer safe in her motorized wheelchair and required the use of a broda chair to get out of bed. LN # 1 reported Resident # 28 shared a broda chair with another resident and the residents switch off days. LN # 1 stated there was an order for a new broda chair in process for Resident # 28.</p> <p>An interview with the Nursing Supervisor on 04/28/11 at 1:54 p.m. revealed Resident # 28 and another resident shared a broda chair that fit both residents properly. The Nursing Supervisor reported the two residents were on a schedule and the residents were never up at the same time. The Nursing Supervisor stated she was not sure if another broda chair was ordered for Resident # 28. The Nursing Supervisor further revealed there were two broda chairs in the facility, one chair being used by a resident on the 100 hallway and the other broda chair that</p>	F 246		

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F 246	<p>Continued From page 3</p> <p>Resident # 28 shared with another resident.</p> <p>An interview with the Director of Nursing (DON) on 04/28/11 at 2:09 p.m. revealed Resident # 28 started sharing the broda chair with another resident on 11/22/10. The DON reported an order request to corporate for new broda chair was initiated on 04/26/11 after Resident # 28's family spoke with her about switching days for the usage of the broda chair in order for the resident to attend certain activities.</p> <p>Another interview with the DON on 04/28/11 at 3:10 p.m. revealed it was part of Resident # 28's rights to get out of bed or refuse to get out of bed when she wanted to. The DON reported she understood the concern with Resident # 28 sharing the broda chair with another resident, and not being able to get out of bed everyday if the other resident was using the chair. The DON further revealed that was why a new broda chair was ordered on 04/26/11 for Resident # 28.</p> <p>An interview with the Administrator on 04/28/11 at 3:15 p.m. revealed Resident # 28 was sharing the broda chair with another resident on different days. The Administrator stated a new broda chair was not ordered when Resident # 28 first started using the broda chair because the two residents agreed to share the broda chair. The Administrator further revealed she understood that Resident # 28 had the right to have access to a broda chair everyday if she wanted to get out of bed.</p> <p>An interview with the Rehabilitation Director on 04/28/11 at 3:30 p.m. revealed a new broda chair was not ordered for Resident # 28 because the</p>	F 246		

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F 246	<p>Continued From page 4</p> <p>representative for the broda chair was no longer in the area and the resident did not get out of bed often. The Rehabilitation Director further revealed she understood that Resident # 28 had the right to have access of a broda chair everyday if she wanted to get out of bed.</p> <p>2. Resident # 66 was readmitted to the facility on 03/21/06 with admitting diagnoses that included diabetes, hypertension, a stroke, and dementia. A review of the most recent annual Minimum Data Set (MDS) assessment dated 02/18/11 revealed Resident # 66 had moderately impaired cognitive skills. The MDS further revealed Resident # 28 required total dependence with the assist of one person for locomotion.</p> <p>An interview with Resident # 66 on 04/28/11 at 3:07 p.m. while she was lying in bed revealed she shared her broda chair with another resident. Resident # 66 reported she would like to get out of bed everyday, but staff would get her up when it was her day to use the broda chair. Resident # 66 stated she could not get out of bed today because it was not her day to use her broda chair. Resident # 66 further revealed tomorrow she would be able to get out of bed because it would be her day to use her broda chair.</p> <p>An interview with the Nursing Supervisor on 04/28/11 at 1:54 p.m. revealed Resident # 66 and another resident shared a broda chair that fit both residents properly. The Nursing Supervisor reported the two residents were on a schedule and the residents were never up at the same time. The Nursing Supervisor stated she was not sure if another broda chair was ordered for the residents' use. The Nursing Supervisor further</p>	F 246		

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F 246	<p>Continued From page 5</p> <p>revealed there were two broda chairs in the facility, one chair being used by a resident on the 100 hallway and the other broda chair that Resident # 66 shared with another resident.</p> <p>An interview with the Director of Nursing (DON) on 04/28/11 at 2:09 p.m. revealed Resident # 66 started sharing her broda chair with another resident on 11/22/10. The DON reported an order request to corporate for new broda chair was initiated on 04/26/11 after the family of the other resident spoke with her about switching days for the usage of the broda chair.</p> <p>Another interview with the DON on 04/28/11 at 3:10 p.m. revealed it was part of Resident # 66's rights to get out of bed or refuse to get out of bed when she wanted to. The DON reported she understood the concern with Resident # 66 sharing her broda chair with another resident, and not being able to get out of bed everyday if the other resident was using the chair. The DON further revealed that was why a new broda chair was ordered on 04/26/11 for the other resident.</p> <p>An interview with the Administrator on 04/28/11 at 3:15 p.m. revealed Resident # 66 was sharing her broda chair with another resident on different days. The Administrator stated she was not aware of a problem with Resident # 66 sharing her broda chair with another resident because the two residents agreed to share the broda chair. The Administrator further revealed she understood that Resident # 66 had the right to have access to a broda chair everyday if she wanted to get out of bed.</p> <p>An interview with the Rehabilitation Director on</p>	F 246		

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F 246	Continued From page 6 04/28/11 at 3:30 p.m. revealed Resident # 66 did not get out of bed often and she agreed to share her broda chair with the other resident. The Rehabilitation Director further revealed she understood that Resident # 66 had the right to have access of a broda chair everyday if she wanted to get out of bed.	F 246	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>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 the 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.</i>		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to provide nail care for one (1) of one (1) dependent resident (Resident # 40). The findings are: A facility policy provided by the Director of Nursing (DON) entitled A.M. Care and dated 04/28/09 revealed that the nursing assistant should inspect the skin of the resident daily, including the fingers and toes, and provide nail care if applicable and appropriate. Resident # 40 was admitted to the facility 10/03/05 with Alzheimer's Disease and psychotic disorder. Her most recent Minimum Data Set (MDS) dated 04/18/11 revealed she had short and long term memory problems and was	F 312	F312 Resident #40 fingernails have been trimmed. She is receiving nail care daily. A one time audit will be conducted by the Unit Manager and or DNS on current resident populations' fingernails to ensure that proper nail care has been performed. The Staff Development Coordinator will re-educate current nursing staff on providing nail care daily and as needed. This in-service will be included in the new employee orientation program for direct care staff. The Director of Nursing and or Unit Manager will assess 10 resident's fingernails twice weekly for one month then monthly for three months to monitor compliance. The Director of Nursing, or her designee, will take appropriate management action with staff members identified as not providing appropriate nail care to residents identified through this assessment process. Audit results will be reviewed and analyzed at the centers' monthly Performance Improvement Meeting (PI) for three months	5/26/2011	

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F 312	<p>Continued From page 7</p> <p>severely impaired in cognitive skills for daily decision making. The MDS also revealed she was totally dependent for most activities of daily living including grooming.</p> <p>A review of the resident's care plan, revised 03/22/11, revealed a problem entitled Potential Alteration in Skin Integrity. Interventions for the problem included a weekly skin condition check, and keeping the fingernails trimmed short and clean. Another care plan intervention was the use of gerisleeves to cover the resident's arms to prevent her from scratching herself.</p> <p>A review of the nursing notes in the medical record of Resident # 40 revealed nurses had been administering an anti-itching medication as needed to prevent the resident from scratching herself, after she had scratched herself and broken the skin with her fingernails.</p> <p>On 04/25/11 at 4:06 p.m. Resident # 40 was observed in her gerichair. Black matter was observed beneath the fingernails of several fingers. The resident's fingernails appeared to be trimmed short except for the thumbnail of the resident's left hand which was approximately 1/4 inch longer than the end of her thumb. The resident was wearing gerisleeves on her arms. Staff were observed preparing to take the resident for a shower.</p> <p>On 04/26/11 at 10:03 a.m. the resident was observed in her gerichair. Her fingernails appeared to be clean and trim med short but the left thumbnail remained the same length as the previous day. The resident was wearing gerisleeves on her arms.</p>	F 312	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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 the 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.</i></p> <p>with a subsequent plan of correction as needed.</p>	

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F 312	Continued From page 8 On 04/27/11 at 9:30 a.m. the resident was observed in her bed. Her left thumbnail remained the same length. Her other fingernails appeared short and clean. The resident was wearing gerisleeves on her arms. On 04/28/11 at 1:30 p.m. the DON was interviewed. She stated the resident often hurt herself by scratching. The DON was taken to observe the resident's fingernails. She noted a scratch on the resident's leg and stated that it may have been a self injury from scratching. She noted that the resident was wearing gerisleeves on her arms and stated that the resident's care plan indicated that geri-sleeves were to be used to prevent scratches. The DON was shown the resident's long thumbnail which remained untrimmed. She stated it should have been trimmed by her staff. She stated she would expect her staff to report it to the nurse if they had a difficult time trimming it due to resident resistance. She stated the resident was showered on Mondays and Thursdays and the nursing assistant should have seen it during the shower on 04/25/11 and reported it to the nurse for trimming. The DON asked the resident's licensed nurse to get nail clippers. The DON assisted the licensed nurse to trim the resident's long thumb nail. The resident offered no resistance to the care.	F 312		