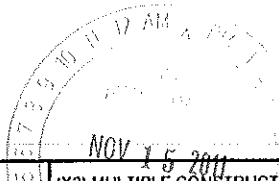


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/10/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/27/2011
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NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3830 BLUE RIDGE ROAD RALEIGH, NC 27612
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(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 309 SS=D	<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 staff interviews and record review, the facility failed to monitor fluids for 1 (Resident #3) of 2 resident on fluid restriction and failed to obtain daily weights for medication administration for 1 (Resident #3) of 1 residents. Findings include: The undated facility policy "Intake and Output Measurement" under the section titled "Procedure: read in part: "7. The intake and output are to be totaled and recorded on the permanent intake and output record every shift; and, 8. Intake and output are totaled every twenty four hours." 1. Resident #3 was admitted to the facility on 09/14/11. Cumulative diagnoses included chronic kidney disease, congestive heart failure, diabetes mellitus and atrial fibrillation. Resident #3 was a recent admission to the facility and a Minimum Data Set (MDS) assessment was not available. Review of Resident #3' s plan of care, dated</p>	F 309	<p>This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.</p> <p><i>F309</i></p> <p><i>How corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice;</i></p> <p>N/A Resident is discharged</p> <p><i>How corrective action will be accomplished for those resident(s) having potential to be affected by the same deficient practice;</i></p> <p>The facility reviewed residents that are on fluid restrictions and are on daily weights. These residents were placed on daily monitoring. New admissions are reviewed for the need to monitor weights and intake and output in morning meetings, and when indicated they were placed on daily monitoring.</p>	<p>11-14-11</p> <p>11-14-11</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 11.14.11
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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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NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
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F 309	<p>Continued From page 1</p> <p>09/20/11, identified as a problem the potential for alteration in nutrition related to fluid restriction ordered second degree to congestive heart failure. One of the goals was compliance with the fluid restriction. One of the interventions listed was to provide the diet as ordered with 1500 cc (cubic centimeters) fluid restriction.</p> <p>Review of the physician's orders, dated 09/14/11, revealed an order for a 1500 cc fluid restriction.</p> <p>Review of a medical record form, dated March 2004, titled "Total Intake and Output Record " was used by the facility to document fluid intake for each shift and then to total the intake for the daily 24 hour period. The documentation on the form for Resident #3's intake was incomplete for 7 of 10 days. There was no documentation of Resident #3's total intake to indicate the resident did not take in more than 1500 ccs in a 24 hour period.</p> <p>An interview, on 10/25/11 at 10:00 AM, was conducted with Nurse #1. She stated the resident was able to feed self; needed assistance for ambulation and confirmed the resident was on a fluid restriction which she documented.</p> <p>An interview, on 10/26/11 at 10:25 AM, was conducted with the Unit Manager (UM). The unit manager stated all fluids taken by a resident on a fluid restriction included the fluids on the meal trays; fluids given with a medication pass; and, any other fluids taken by a resident should be documented on the form titled "Total Intake and Output Record". Upon review of the form, the UM relayed the form should have been completed by the nurse on each shift and the</p>	F 309	<p><i>Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur;</i></p> <p>New residents admitted as well as residents with new doctor's orders will be reviewed for the need to monitor their weight changes and or intake and output monitoring. When indicated they will be placed on daily monitoring and discussed at shift change and morning meetings for follow up.</p> <p>Nurses and CNA's were in-serviced on the timely and accurate reporting and documentation of intake and output or weight monitoring per policy or per doctor's orders. Nurses will record the 24 hour total intake and output for analysis. Weights will be entered on the weight monitoring sheets.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained. Plan to ensure for ensuring that the correction is achieved and sustained. How implementation of the corrective action is evaluated for its effectiveness, and integration into the quality assurance system of the facility.</i></p> <p>The Unit Managers will conduct a daily audit of all residents on fluid restrictions to ensure accurate reporting and totals are obtained, and weights are recorded. Inaccuracies will be evaluated for disciplinary measures. (see audit).</p> <p>A weekly QA will be conducted (We Care) Where these residents will be reviewed by the Director of Nursing / ADON and Registered Dietician. Review of systems will be discussed in the Monthly QA.</p>	11-14-11	11-14-11

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NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(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 309	<p>Continued From page 2</p> <p>total fluid intake should have been completed by the night nurse. When asked what should have been done regarding the incomplete documentation, she indicated it should have been brought to her attention so that she could address the issue to assure the resident was only receiving 1500 ccs.</p> <p>An interview, on 10/26/11 at 11:00 AM, was conducted with Nurse Aide (NA) #1. NA #1 confirmed she had provided care for Resident #3 and stated he really liked to have coffee. She indicated she would check with the nurse before giving him extra fluid. The NA relayed she documented, on her daily assignment form, the resident ' s intake. She stated at the end of a shift, the NAs give the form to the nurse with the total intake for that shift.</p> <p>An interview, on 10/26/11 at 1:30 PM, was conducted with NA #2, working at Nursing Station II. NA #2, who also had a resident on a fluid restriction, stated she keeps the total for the resident ' s fluid intake for her shift and then documented the amount on a list that was kept at the nursing station desk.</p> <p>An interview, on 10/26/11 at 1:45 PM, was conducted with the Director of Nursing (DON). The DON confirmed when a resident was on a fluid restriction, the amount should be recorded on each shift and totaled for the 24 hours period. He relayed he felt the resident did not receive more than the 1500 cubic centimeters (cc) of fluid in a 24 hour period as the resident did not always take the total amounts of liquid on the meal tray. The DON indicated the facility would be addressing the issue of fluid restriction.</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>2. 1. Resident #3 was admitted to the facility on 09/14/11. Cumulative diagnoses included chronic kidney disease, congestive heart failure, diabetes mellitus and atrial fibrillation.</p> <p>Resident #3 was a recent admission to the facility and no Minimum Data Set (MDS) assessment was available.</p> <p>Review of Resident #3's plan of care, dated 09/20/11, identified as a problem the potential for alteration in nutrition related to a therapeutic diet being in use and fluid restriction ordered second degree to congestive heart failure. One of the goals was to maintain weight plus or minus two pounds. One of the interventions listed was to monitor weights as ordered.</p> <p>Review of the physician orders, dated 09/14/11, revealed an order for Torsemide 10 mg (milligrams) by mouth when needed for a weight gain over three pounds in a 24 hour period or a weight gain over five pounds in a 48 hours period.</p> <p>Review of an undated form titled "Weight Tracker" the resident's admission weight was 212 pounds; and, there were no weights recorded for 09/15/11; 09/16/11; 09/17/11; and 09/18/11. A weight of 205 pounds was recorded on 09/19/11.</p> <p>Review of the Medication Administration Record (MAR) revealed the first daily weight documented was 205 pounds on 09/19/11.</p> <p>An interview, on 10/25/11 at 2:45 PM, was conducted with Nurse #2 who completed the</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>nursing admission form on 09/14/11. She reviewed the physician ' s orders for Torsemide and indicated daily weights would be needed in order to administer the medication. Nurse #2 relayed when she had an order like that she would fill out and send a communication form to restorative nursing to complete daily weights. Upon review of the medical records, she indicated she did not see the form in the record and would need to research if she or another nurse might have filled out a form.</p> <p>An interview, on 10/26/11 at 10:25 AM, was conducted with the Unit Manager (UM). The UM reviewed the order and the weights then stated that weights should have obtained daily starting on 09/14/11. She indicated the daily weights were started on the 09/19/11when a nurse noticed the daily weights were needed and sent a communication to restorative to obtain daily weights.</p> <p>An interview, on 10/26/11 at 12:25 PM, was conducted with the Restorative Aide (RA) #1. The RA confirmed restorative nursing completed daily weights and would receive a communication form with the information regarding a resident. He indicated restorative nursing was unaware of the need of a daily weight for Resident #3 until 09/19/11. The RA indicated restorative nursing received the communication form on 09/19/11 and completed the weight that day and the following days.</p> <p>An interview, on 10/26/11 at 12:30 PM, was conducted with the Director of Nursing (DON). The DON relayed his expectation was the daily weights should have been completed per the</p>	F 309			

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F 309	Continued From page 5 order of the medication, which would have needed daily weights in order for the medication to be given if necessary.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to obtain weights prior to administration of a diuretic medication for 1 (Resident #3) of 1 sampled residents.	F 329	<i>F 329 – Unnecessary meds</i> <i>How corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice;</i> N/A Resident discharged <i>How corrective action will be accomplished for those resident(s) having potential to be affected by the same deficient practice;</i> The facility reviewed all residents that takes medication that require specific monitoring measures like weight changes. These residents were re-assessed for the continuing need to monitor and placed on monitoring as ordered. New residents who may present the need for same weight monitoring were reviewed in shift reports and morning meetings. Once indicated they are placed on the required monitoring.	11-14-11 11-14-11

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F 329	<p>Continued From page 6</p> <p>Findings include:</p> <p>Resident #3 was admitted to the facility on 09/14/11. Cumulative diagnoses included chronic kidney disease, congestive heart failure, diabetes mellitus and atrial fibrillation.</p> <p>Resident #3 was a recent admission to the facility and a Minimum Data Set (MDS) assessment was not available.</p> <p>Review of Resident #3's plan of care, dated 09/20/11, identified as a problem the potential for alteration in nutrition related to a therapeutic diet being in use and fluid restriction ordered second degree to congestive heart failure. One of the goals was to maintain weight plus or minus two pounds. One of the interventions listed to monitor weights as ordered.</p> <p>Review of the physician orders, dated 09/14/11, revealed an order for Torsemide 10 mg (milligrams) by mouth when needed for weight gain over three pounds in a 24 hour period or weight gain over five pounds in a 48 hours period.</p> <p>Per Lexi-Comp's Drug Reference "Geriatric Dosage Handbook" 14th Edition, Torsemide is used to treat edema.</p> <p>Review of an undated form titled "Weight Tracker" the resident's admission weight was 212 pounds; and, there were no weights recorded for 09/15/11; 09/16/11; 09/17/11; and 09/18/11. A weight of 205 pounds was recorded on 09/19/11.</p> <p>Review of the Medication Administration Record,</p>	F 329	<p><i>Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur;</i></p> <p>New admissions, new orders of medications that required monitoring of weights for evaluation will be discussed at the shift reports and the morning meetings to ensure that the appropriate monitoring is in place.</p> <p>Nurses and CNA's were in-serviced on monitoring requirements of medications and or disease conditions of residents. The Documentation and the checking of this information such as weights and intake and output were emphasized. Accuracy and timely record keeping were highlighted (See in-service). A Medication double check system was initiated. This system requires a second check of all medication orders to be performed by the next shift. This will ensure all medications and its required parameters directs the nurse to check important requirements (see- in-service).</p>	11-14-11

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F 329	<p>Continued From page 7</p> <p>dated 09/14/11 - 09/30 11, revealed Resident #3 received a dose of Toresmid 10 mg on 09/19/11. On the back of the medication administration record the nurse documented the medication was given for weight gain.</p> <p>An interview, on 10/26/11 at 10:35 AM, was conducted with Nurse #1, who administered the medication. The Nurse indicated she did not remember why the dose was given. She confirmed the medication was to be given for a weight gain over three pounds in a 24 hours period or a weight gain over five in a 48 hour period.</p> <p>An interview, on 10/26/11 at 11:15 AM, was conducted with Resident #3's Medical Doctor (MD). When asked about the dose of Torsemide being administered, the MD indicated it would be difficult to determine any negative effect because there was a difficult balance between CHF and renal failure. He relayed the problem with diuretics versus hydration was an ongoing problem.</p> <p>An interview, on 10/27/11 at 11:15 AM, was conducted with the Director of Nursing (DON). The DON relayed his expectation was that the medication would have been given as ordered.</p>	F 329	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained. Plan to ensure for ensuring that the correction is achieved and sustained. How implementation of the corrective action is evaluated for its effectiveness, and integration into the quality assurance system of the facility.</i></p> <p>The Unit Managers will conduct a daily audit of all residents on daily weights, to ensure accurate reporting and documentation. Managers will review all orders to ensure the double check system has been applied. Inaccuracies will be addressed (see audit).</p> <p>A Weekly QA meeting (We Care) will be conducted to ensure the overall process is being observed. The Director of Nursing or designee to ensure compliance. Review of systems will be discussed in the Monthly QA.</p>	11-14-11