STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	12/15/2011

JAN 18 2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

(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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based upon observations, and staff interviews, the facility failed to promote residents dignity by not serving and assisting dependent and cognitively impaired residents during meal observations in 1 of 1 dining room, while other residents in the same dining room were engaged in meals. Findings Include: A lunch meal observation occurred in the main dining room on 12/12/11 at 12:26 PM. There were two residents seated at a dining table located in the middle of the dining room. Each resident had a meal tray placed in front of them. A Nursing Assistant (NA) was assisting feeding one of the residents. The NA completed feeding the resident and began feeding the other resident at 12:46 PM. A lunch meal observation occurred in main dining room on 12/13/11 at 12:24 PM. There were three residents seated together at a dining table located next to the entrance into the dining room. One resident had his meal tray served and was eating his food. The other two residents did not have a meal tray served. The second resident was served his meal at 12:37 PM and began	F 241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Stanley	Administrator	1/12/12

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 241	Continued From page 1 feeding himself. The last Resident was served his meal tray at 12:39 PM. The NA began assisting feeding this Resident at 12:39 PM. A lunch meal observation occurred in main dining room on 12/13/11 at 12:24 PM. There were two residents seated at a dining table next to the kitchen. Each resident had a meal tray in front of them. One resident was independently feeding herself. The other resident had a meal tray in front of her. A NA had begun to feed the second resident at the table at 12:45 PM. A record review of the minimum data sets for cognitive status and eating ability were reviewed for the residents observed having to wait for their meals during the dining observations. All residents were at a poor cognitive status. Their eating ability required extensive to total assistance at meals. One resident required supervision at meals. An interview with NA#1, on 12/14/11 at 11:18 AM revealed staff attempted to give independent residents their meal tray first and gave dependent residents their meal tray last. NA#1 indicated that sometimes staff could not control the way some meal trays should be passed out by other staff. An interview with NA#2, on 12/14/11 at 11:32 AM, revealed the dining room goal was to sit dependent residents together to be fed at the same time, but there were some residents that want to sit in certain places. There was no strategy in place for assisting dependent residents while independent residents were eating at a dining table.	F 241	1. Dependent and cognitively impaired residents in the facility dining room were served and assisted with meals while other residents in the facility dining room were engaged in meals. Dept Heads are assigned to dining room duty daily to assure meals were served to dependent and cognitively impaired residents at the same time as others in the dining room.. 2. Daily Quality Assurance monitoring will be conducted by Dept Heads within the facility to visualize no other areas of concern identified as related to a dignified dining experience for current dependent and cognitively impaired residents. Nursing staff were educated on the facility policy and procedure for dining services as to promote a dignified dining experience for dependent and cognitively impaired residents. Dept Head,/Supervisor/Manager on Duty will monitor daily each meal.	01/12/12 01/12/12

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F 241	Continued From page 2 An Interview with the Dietary Manager, on 12/14/11 at 11:54 AM, revealed the NAs passed out meal trays. They try to seat the dependent residents together to be fed at same time. If the dependent residents were sitting with independent residents, the goal was to assist feeding the dependent residents. An interview with NA#3, on 12/15/11 at 10:45 AM, revealed staff try to seat all dependent residents together but sometimes this did not work out. She would ask a dependent resident if it was alright to provide the independent resident their meal first. An interview with the Director of Nursing, on 12/15/11 at 11:17 AM, revealed she had in-serviced her staff on feeding assistance in the dining room. She indicated some residents preferred to sit in certain places. If an independent resident preferred to sit with a dependent resident, the NA staff would wait last to serve those tables. The meal trays were expected to be served at the same time. The NAs would then assist the dependent residents. She would not expect for dependent residents to be served food without feeding assistance, while other residents were engaged in eating at a dining table.	F 241	3. ADMIN/DON will conduct Quality Improvement (QI) monitoring of dignified meal experience will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/DON will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.	01/12/12 01/12/12
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242		

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F 242	Continued From page 3 are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to honor 1 (Resident #42) of 1 sampled resident ' s choice to be out of bed prior to smoking scheduled time. Findings include: Resident #42 was admitted to the facility on 07/27/07 and readmitted on 08/11/10. Cumulative diagnoses included quadriplegia and spasticity of all extremities. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/21/11, revealed the resident was alert and orient, had no moods or behaviors. The assessment indicated Resident #42 did require total assistance from staff for transfers; dressing; eating; tolieting; bathing; was able to be independent with locomotion in the facility; and, had limited range of motion in all extremities. Further review of the MDS did not reveal the resident refused care or services. During the survey, the facility was observed to announce over the paging system the times for smoking at 9:30 AM; 11:00 AM; 1:30 PM; 3:30 PM; and 6:30 PM. On 12/14/11 at 8:55 AM, an observation was made of the resident sitting up in his motorized wheelchair being fed by Nurse Aide (NA) # 5. The resident confirmed he was ready for the day. On 12/14/11 at 9:30 AM, an observation was	F 242	1. Resident # 42 was assisted out of bed prior to the next scheduled smoking time. CNA's assignment sheet and care tracker profile was update to resident's preference. 2. Dept Heads will monitor within the facility daily to visualize no other areas of concern identified as related to current residents requiring assistance who choose to be out of bed prior to a scheduled smoking time. Current residents who smoke have been interviewed to identify their preference to be up prior to the first scheduled smoking session. Those residents profile have been updated in care tracker. Current nursing staff was educated on the facility policy and procedure for residents rights to promote that residents requiring assistance are out of bed per their choice prior to a scheduled smoking time. 3. ADMIN/DON will conduct QI monitoring of residents that want to get up for the first smoke break are up 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/DON will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	01/12/12 01/12/12 01/12/12 01/12/12

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F 242	Continued From page 4 made of Resident #42 exiting the building to smoke. An interview, on 12/14/11 at 2:44 PM, was conducted with NA #1. The NA indicated the resident liked to go out at the scheduled smoking times during the day. On 12/15/11 at 9:40 AM, an observation was made of the resident in bed. Resident #42 stated no one had gotten him up yet and he was missing the first smoking break. He relayed that it happened a lot because he felt they did not have enough staff. Resident #42 continued when they did get him up, it will be too late to go out to smoke and he will have to wait until the next time. He indicated the issue happened often enough that is really does upset him. He reiterated it upsets him that he can ' t get up when he wants or go to smoke when he wants. A continuous observation began at 9:40 AM. No nursing staff was noted to access the Resident #42 ' s room between 9:40 AM and 10:10 AM. On 12/15/11 at 10:10 AM, an observation was made of Resident #42 ' s call light to be on. The Director of Nursing (DON) was observed to answer the call light and to return to the nursing station to check on NA assignment. The DON stated the NA was in a room giving care. On 12/15/11 at 10:25 AM, NA #5 and NA #3 were observed to go into the resident ' s room and closed the door. An interview, on 12/15/11 at 10:45 AM, was conducted with NA #5, who confirmed she was	F 242		

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F 242	Continued From page 5 assigned to Resident #42 on this date. NA #5 confirmed the resident did like to be able to go out at the first smoking time. When asked why he was not able to be up earlier this date, she stated she had been busy with and had been unable to get to him to get him up. NA#5 indicated on some days if the resident was not feeling good he would not get up early. When asked if that was the reason he was not up to day, NA #5 said no. On 12/15/11 at 10:47 AM, Resident #42 was observed up in his motorized wheelchair, sitting in the hallway and confirmed he was waiting for the next smoking time. An interview, on 12/15/11 at 10:55 AM, was conducted with NA #2. She confirmed Resident #42 liked to be up in time to go out to smoke at the 9:30 AM scheduled time. Review of the resident ' s medical record did not reveal any documentation Resident #42 refused care. The medical record did not indicate the resident went out at different times to smoke. An interview, on 12/15/11 at 11:10 AM, was conducted with the Director of Nursing (DON) in the presence of the administrator. She relayed when he put his light on she gave the information to the NA and he was taken care of. The Administrator indicated sometimes the resident refused to get up when staff was available. The Administrator continued that if the resident did get up later, they would have staff take him to smoke. An interview, on 12/15/11 at 2:10 PM, was conducted with the Resident #42. He stated the	F 242		

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F 242	Continued From page 6 staff knew to get him up after breakfast because he wanted to go out at 9:30 AM to smoke. Resident #42 relayed he did not go out at the 6:30 PM scheduled smoking time as he was in bed at that time because he gets tired up in his chair.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to address a problem identified as constipation and develop a comprehensive care plan for resident #4. The facility failed to include resident #4 had a history	F 279	1. Resident #4's care plan was updated to include the problem of constipation and fecal impaction. Resident #4's Minimum Data Set (MDS) was updated to include a history of fecal impaction. Current MDS 10/24/11 reflects resident history of fecal impaction. 2. Licensed nursing staff were educated on the policy and procedure for developing a comprehensive plan of care as to promote that the problem of constipation is addressed for applicable residents. Current MDS Coordinator was educated on the policy and procedure for completion of the MDS as to promote that fecal impaction is included for residents with a history. 100% chart audit was completed to identify resident with constipation diagnosis/history of constipation and fecal impaction. 100 % audit of current MDS assessment were audited to insure that they reflected fecal impaction and constipation as indicated. Medical Records for residents with the diagnosis of constipation were updated.	01/12/12 01/12/12

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F 279	Continued From page 7 of a fecal impaction on the Minimum Data Set. Resident # 4 was admitted to the facility on 3/4/05. Cumlative diagnosis included Osteoarthritis, Cerebral vascular Accident (stroke) with left hemiparesis (paralysis), Type II Diabetes, Hypothyroidism, and Pelvic Fracture with right hip pinning. A review of the most recent Minimum Data Set (MDS): dated 10/24/11, revealed the resident was continent of bowel, and, at times, incontinent of urine. Constipation was checked on MDS section 6 and triggered constipation. A fecal impaction was not stated on the MDS. A review of the Care Plan dated 10/11 revealed that constipation was not identified as a problem for Resident #4 and was not included in the resident ' s plan of care. Medications for this resident include Miralax for constipation. During a review of the nurses ' notes, dated 7/31/11, revealed the resident had a fecal impaction. The nurse documented that the resident complained of constipation and that she could not pass the stool. The nurse saw a small amount of blood in the toilet. The nurse checked the resident for impaction and documented the resident had a large amount of hard stool in the rectum. The nurse contacted the physician and notified him of the findings. He ordered the nurse to manually disimpact the resident and then give a half a bottle of Magnesium Citrate. The stool was removed and the patient received the Magnesium Citrate as ordered. A further review of the medical record, Medication Administration Record (MAR) and the Care Tracker Bowel and	F 279	3. ADMIN/DON will conduct QI monitoring of care plans and MDS to insure that they include fecal impaction and constipation as indicated. 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/DON will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	01/12/12 01/12/12

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F 279	Continued From page 8 Bladder Detailed Report revealed the resident had several episodes without a reported bowel movement for 3 days or longer. The MAR revealed that this patient had an order for Milk of Magnesia (MOM) to be given if needed for constipation. Resident #4 ' s recorded bowel movements were as follows: a. August 2011, the resident had no bowel movement from 8/10/11 through 8/16/ 11 and again from 8/19/11 through 8/ 26 /11. b. September 2011, the Care Tracker Bowel and Bladder Detailed Report revealed that resident had no bowel movement from 9/4/11 through 9/10/11. From 9/11 through 9/19 no BM was recorded. The nurses note on 9/14/11 stated the resident was checked for impaction, no stool felt, and the nurses would continue to monitor. c. October 2011, review of the Care Tracker BM reports for the resident revealed that the resident had a BM on 10/4/11. On 10/7/11 the resident was sent to Emergency Room for chest pain. The resident was seen in the Emergency Room and returned to the facility that night with a diagnosis of Gastro esophageal Reflux. The next documented BM was on 10/8/11. On 10/12/11 Physician progress notes state resident was seen for a follow up visit for chest pain and shortness of breath. He documents the visit to the Emergency Room as uneventful. "They thought it was probably indigestion. She does have a challenge with constipation." On 10/9/11 to 10/15/11 no bowel movement was documented on Care Tracker system. From 10/20/11 to 10/26/11, no bowel movement was documented	F 279		

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F 279	Continued From page 9 in the Care tracker system. d. November 2011, review of the Care tracker system revealed that the resident had no BM 11/13/11 through11/20/11. During an interview with the MDS nurse 12/15/11 at 10:00AM, she stated the patient should have a care plan for constipation.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with facility staff, the facility failed to assess and monitor bowel patterns of 1 (Resident #4) of 1 sampled residents, who had a documented history of a fecal impaction and constipation. Resident # 4 was admitted to the facility on 3/4/05. Multiple diagnosis include: Osteoarthritis, Cerebral vascular Accident with left hemiparesis, Type II Diabetes, Hypothyroidism, and a Pelvic Fracture with right hip pinning. A review of the most recent MDS (Minimum Data Set) with an Assessment Reference Date of 10/24/11, revealed that Resident #4 needed	F 309	1. Resident # 4 had bowel patterns assessed and suffered no harm. Reviewed BM report from care tracker and resident was having documented BM's regularly. MD reviewed medication and new orders received for Mira- lax daily. 2. Nurse Managers will review residents daily for No BM in nine shifts care BM report to insure residents are having regular BM's. Any resident identified as constipated will be reported to the MD for further interventions. CNA's were educated on asking residents with independent toileting to insure accurate documentation of BM patterns.. Licensed nursing staffs were educated on the policy and procedure for nursing assessment to promote assessment of bowel patterns for residents with a documented history of fecal impaction and constipation.	01/12/12 01/12/12

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F 309	Continued From page 10 extensive assistance for weight bearing and transfers. Staff set up for bathing and assistance for bathing was required. The resident was continent of bowel and incontinent of urine at times. Multiple medications for this resident included Lyrica for pain management and Miralax for constipation. During a review of a nurses note, dated 7/31/11, revealed the resident had a fecal impaction. The nurse documented that the resident complained of constipation and that she could not pass the stool. The nurse saw a small amount of blood in the toilet. The nurse checked the resident for impaction and documented the resident had a large amount of hard stool in the rectum. The nurse contacted the physician and notified him of the findings. He ordered the nurse to manually disimpact the resident and then give a half a bottle of Magnesium Citrate. The stool was removed and the patient received the Magnesium Citrate as ordered. The nurse documented in the notes that the patient was to be monitored for effectiveness of the treatment for constipation. The next nurse ' s note entry was written on 8/3/11. Nurse notes did not include documentation of an abdominal assessment by the nurse. A further review of the medical record, Medication Administration Record (MAR), and the Care Tracker Bowel and Bladder Detailed Report completed by Nursing Assistants, revealed Resident #4 had several episodes without a reported bowel movement for 3 days or longer. The MAR indicated the resident had an order for	F 309	3. ADMIN/DON will conduct QI monitoring of bowel movement report/care tracker BM report daily to insure residents are having regular documented BM's monitoring will continue 5 x weekly x 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/DON will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	01/12/12 01/12/12

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F 309	Continued From page 11 Milk of Magnesia to be given as needed for constipation. A review of the physician orders and the MAR revealed that the Milk of Magnesia (MOM) had not been given June, July, August, September, and October of 2011. Review of the resident ' s documented bowel pattern revealed the following; a. August 2011, the resident had no bowel movement from 8/10/11 through 8/16/ 11, and from 8/19/11 through 8/ 26 /11. Review of the medical record revealed no assessments of the resident ' s abdomen were done. Review of the physician orders and the Medication Administration Record (MAR) for those time periods revealed the resident had an order for Milk of Magnesia to be given as needed for constipation, but was not documented as used the entire month of August. b. September 2011, the Care Tracker Bowel and Bladder Detailed Report revealed the resident had no bowel movement from 9/4/11 through 9/10/11. No abdominal assessments were documented in the nurse ' s notes. From 9/11/11 through 9/19/11 there were no recorded bowel movements (BMs). The nurse ' s note on 9/14/11 stated the resident was checked for impaction, no stool was felt, and the nurses would continue to monitor. No abdominal assessment was documented. A review of the physician ' s progress notes revealed that on 9/11/11, nursing requested the physician to see the resident for a 4 pound weight loss over 30 day period. According to the physician ' s note, the resident stated many times she was not hungry and did not want to eat. He documented he had no knowledge of vomiting or diarrhea for this	F 309		

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	345406	A. BUILDING _____ B. WING _____	12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

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F 309	Continued From page 12	F 309		

resident. A review of the MAR and physician orders revealed the resident had an order for Milk of Magnesia to be given as needed for constipation. The medication was not used the entire month of September 2011.

c. October 2011, a review of the Care Tracker BM reports for the resident revealed that the resident had a BM on 10/4/11. On 10/7/11 the resident was sent to Emergency Room for chest pain. The resident was seen in the Emergency Room and returned to the facility that night with a diagnosis of Gastro-esophageal Reflux. The next documented BM was on 10/8/11. On 10/12/11, a Physician progress note stated the resident was seen for a follow up visit for chest pain and shortness of breath. He documented the resident ' s visit to the Emergency Room as uneventful. "They thought it was probably indigestion. She does have a challenge with constipation." From, 10/9/11 to 10/15/11 no bowel movement was documented on the Care Tracker system. No assessment was documented in the nurses ' notes. From 10/20/11 to 10/26/11 no bowel movement was documented in the Care tracker system. The physician orders and the MAR were reviewed and it revealed that the resident had an order for Milk of Magnesia to be given as needed for constipation, but was not used the entire month of October 2011. A review of the Physician ' s orders, dated October 28, 2011 revealed that the Milk of Magnesia was discontinued for non-use.

d. November 2011, a review of the Care tracker system revealed that the resident had no BM from 11/13/11 through11/20/11. A review of the nurses ' notes revealed that no assessment was done by nursing. From 11/24/11 through 12/1/11, no BM was recorded through the Care Tracker

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F 309	Continued From page 13 System. A nurse ' s notes on 12/1/11 indicated the resident told the nurse she had a bowel movement on 11/28/11 and 11/30/11. During an interview with NA #1, on 12-15-11 at 11:22 AM, the NA reported she was familiar with the resident. The NA described the resident ' s appetite as fair, that she ate a good breakfast, and snacks, but less for lunch unless it was some thing she really liked. The NA further reported the resident could take herself to the bathroom, but she shouldn't because she's not safe to walk by herself. The NA stated the resident would use her call light when she was done in the bathroom. The NA stated the resident did not flush the commode or clean herself after using the toilet. The NA stated staff provided hygiene care and assisted her out of the restroom. During an interview with NA #5 on 12-15-11 at 11:30 AM, the NA reported she was familiar with the resident. The NA reported the resident ' s appetite in the morning may have been 50%, lunch maybe 25%, she drank well, and ate snacks. The NA reported she entered residents ' bowel movements into the Care Tracker system. During an interview, with the RN Nursing Supervisor on 12/15/11 at 9:50 AM, the RN revealed resident BM's were documented in the Care Tracker system by the NAs. The Supervisor stated a 72-HOUR Report was generated from the Care tracker and was reviewed on a daily basis. The supervisor stated monitoring was done for those residents that were on the 72-Hour report sheet through nursing assessments of bowel sounds and checked for	F 309		

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F 309	Continued From page 14 pain or discomfort. The Supervisor stated the NAs also reported to the nurse at the end of the shift which resident had a BM. The Supervisor reported nurses documented the BM ' s on the MAR. In addition, the resident was offered a constipation medication, if ordered. An interview with the DON (Director of Nursing) on 12/15/11 at 12:30 PM, revealed that BM reporting and tracking was done by the NAs using the Care tracker system each shift. The NA reported to the nurse at the end of their shift if the residents in her care had a BM. The 72-hour BM report sheet was printed from the Care Tracker system which revealed which residents did not have a BM in 72 hours. The DON stated the report was reviewed by herself and the Supervisor daily at the clinical meeting. The DON stated the information was communicated to the Charge Nurses on the units caring for the residents. The DON stated nurses were expected to follow through with an assessment for residents who have not had a BM in 72 hours to include bowel sounds, abdominal tenderness, pain or discomfort. The DON stated nurses also checked physician orders for constipation medication if indicated and contacted the doctor if indicated. The information was expected to be documented in the nurses ' notes for the resident. A review of Resident #4 ' s medical record and facility documentation regarding a bowel protocol with the DON revealed the resident ' s documented impaction on 7/31/11. The DON stated she was not employed by the facility at that time. The DON did not recall the resident being triggered on her 72-hour report for BMs since she	F 309		

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F 309	Continued From page 15 has been at the facility. The DON stated that beginning September 1, 2011, the nurses no longer record the BM in the MAR. The DON stated she had changed the process and eliminated the "double charting on the MAR " . The physician ' s order for this resident dated, September 1, 2011 stated Discontinue checking for BM every shift if no BM in 3 days check for impaction. " indicated that was Nursing documentation for Resident #4 was reviewed with the DON. Review of the resident ' s MAR with the DON, revealed the resident had order for Miralax (laxative used to promote bowel movements) ever other day. The medication had been used daily, but the physician reduced it to every other day. In addition, the resident had an order for MOM for constipation to be used on an " as needed " basis- and the order was discontinued on 10/28/11 for non use. Review of the resident ' s MARs since June 2011 confirmed the MOM had not been given June 2011 through the date it was discontinued on October 28, 2011. The DON stated it was her expectation that the MOM should have been given as the resident had gone longer than 72 hours without a bowel movement. The Nurse Consultant participated in the interview as she was more familiar with Care Tracker system. The Nurse Consultant stated that when a person showed up on 72-hour report, the resident should continue to show up on the report until a bowel movement was documented in the system.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		

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F 318	Continued From page 16 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based upon observations, staff interviews and record reviews, the facility failed to provide the appropriate treatment devices to prevent further decrease in range of motion for 1 of 3 sampled Residents (Resident #13) with contractures. Findings Include: Resident #13 had diagnoses of congestive heart failure, edema, Alzheimer's, stroke and neuropathy. The Minimum Data Set, dated 10/7/11, indicated Resident #13 was at a poor cognitive status and required extensive to total assistance with her activities of daily living. Resident #13 had a limited Range of Motion (ROM) on one side with partial loss of voluntary movement. She was at risk for skin breakdown. An observation on 12/12/11 at 2:36 PM revealed Resident #13 was unable to move her left hand and had curled fingers on the left hand. A record review of the facility physician orders was conducted. An order dated 7/27/11 indicated the resident was to wear an edema glove and left hand wrist seven days per week and was to be applied after daily morning care. A record review of the facility Occupational Therapy (OT) Progress Report,, dated 7/14/11	F 318	1. Resident #13 had the splint placed to her left hand/wrist as per physician's orders. Resident #13's edema glove was discontinued per physician's orders. New orders were obtained and a splint was applied to left hand/wrist and will be applied by nursing staff per physicians order. 2. Nursing and Therapy conducted a 100% building audit of resident for splinting needs. Orders were obtained clarified by the physician for orders for splints. Nursing staff will apply and remove splint per Physician Order as applicable. Nursing staff were educated on the facility policy and procedure for application of splinting devices as to promote provision of appropriate treatment devices to prevent further decrease in range of motion for current residents with contractures.	01/12/12 01/12/12

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F 318	Continued From page 17 through 7/29/11 was conducted. The report indicated the long term goal was for Resident #13 was to utilize the left grip splint and edema glove to the left hand and wrist for contracture prevention and edema management. It indicated Resident #13 met OT goals and was able to wear a left grip splint and edema glove for eight hours with no signs or symptoms of decreased skin integrity. A record review of the facility therapy to Restorative Nursing recommendations, dated 6/16/11, was conducted. It indicated for restorative services to place the left hand/wrist splint as directed by OT daily until discontinued. A record review of the facility Restorative Nursing program plan and summary, dated 7/21/11, indicated the goal was to prevent contractures. It indicated for nursing staff to apply the left hand grip splint on during the day and off during the evening. An observation on 12/15/11 at 2:56 PM, revealed Resident #13 was seated in a reclining chair in her room. Her left hand was limp and unable to be used. There was no edema glove or splint device on her left hand. An interview with the Rehabilitation Director, on 12/15/11 at 3:31 PM, revealed Resident #13 was supposed to be wearing a hand splint and edema glove to prevent edema and contractures. She has had edema to the left hand. According to the Rehabilitation Director's review, the last order would be for the use of a left hand splint and edema glove. There was a schedule for the length of time the splint was suppose to be worn.	F 318	3. ADMIN/DON will conduct QI monitoring that splints are in place per physician order 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/DON will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	01/12/12 01/12/12

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F 318	Continued From page 18 An observation on 12/15/11 at 3:41 PM revealed Resident #13 in a reclining chair in her room. Resident #13 was not wearing a splint device or edema glove. An interview with Nursing Assistant #4, on 12/15/11 at 3:50 PM, revealed she had come in the mornings and observed Resident #13 with a glove on, but she was unsure of Resident #13 wearing a splint. She knew there was an order for a glove, but was unsure about a splint order. An interview with the Restorative Nurse on 12/15/11 at 4:48 PM, revealed Resident #13 had progressed with restorative services for ROM and feeding. She was not sure about a left hand splint and edema glove to be worn. An interview with the Restorative Nurse on 12/15/11 at 5:28 PM, revealed she could not find a discontinued order for the left hand splint or edema glove. As far as she knew, the order to wear the hand splint and edema glove still remained. An interview with Director of Nursing, Administrator and Nurse Consultant on 12/15/11 at 6:20 PM, revealed they agreed that the left had splint and edema glove should have been placed on Resident #13.	F 318		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/10/2012

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K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday January 10, 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The ceiling flashing around the exhaust vent in the water heater room located at the end of F-Hall accessible from outside is not secured to the ceiling. 2) Throughout the building the area around the sprinkler heads are not properly sealed in order to maintain the rating of the ceiling. 3) The roll up shutter located between the dinning room and kitchen dish return area was missing hardware at the top and when closed would not seal the area in order to maintain the required rating for the wall. 42 CFR 483.70(a)	K 012	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. K-012 1. The ceiling flashing around the exhaust vent in the water heater room located at the end of F-Hall accessible from outside was repaired to secure to the ceiling. Areas around the sprinkler heads throughout the facility are properly sealed to maintain the rating of the ceiling. The roll up shutter between the dining room and kitchen dish return areas has been replaced. Waiver requested for the roll-up shutter until 3/30/2012. 2. Quality Assurance rounding was conducted throughout the facility to visualize no other areas of concern identified as related to the ceiling flashing around the exhaust vent; sprinkler heads through out the facility and the roll up shutter in the dining room. Maintenance Director educated that ceiling flashing around the exhaust vent is secured to the ceiling, the area around the sprinkler heads throughout the facility are properly sealed, and the roll up shutter in the dish return area seals properly when closed. 3. ADMIN/Designee will conduct Quality Improvement (QI) monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/Designee will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Completion date 2-14-2012	2/14/12 2/14/12 3/30/12 2/14/12 2/14/12 2/14/12
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday January 10,	K 038		

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Pamela Harvey, Administrator — 1/27/2012

leficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing 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 ollowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued un participation.

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K 038	Continued From page 1 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The delayed egress exit doors at the end of A and C hall did not release upon activation of the fire alarm. 42 CFR 483.70(a)	K 038	K 038 1. The delayed egress exit doors at the end of A and C hall releases upon activation of the fire alarm. BFPE repaired on 1/11/2012. 2. Quality Assurance rounds was conducted to assure that other delayed egress exit doors in the facility released upon activation of the fire alarm. No further issues identified. Maintenance Director re-educated on that the delayed egress exit doors must release when fire alarm is activated. 3. ADMIN/Designee will conduct QI monitoring that egress exit doors release upon activation of the fire alarm. This standard will be monitored 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/Designee will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Completion date 2-14-2012	2/14/12
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday January 10, 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The tamper alarm for the sprinkler valve located in front of the intake on the fire pump did not provide a supervisory signal at the fire alarm panel when tested.	K 062		2/14/12 2/14/12 2/14/12
K 067 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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K 038	Continued From page 1 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The delayed egress exit doors at the end of A and C hall did not release upon activation of the fire alarm. 42 CFR 483.70(a)	K 038		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday January 10, 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The tamper alarm for the sprinkler valve located in front of the intake on the fire pump did not provide a supervisory signal at the fire alarm panel when tested.	K 062	K 062 1. The tamper alarm for the sprinkler valve located in front of the intake on the fire pump does provide a supervisory signal at the fire alarm panel when tested. BFPE repaired the tamper alarm switch on 1/19/2012. 2. Quality Assurance rounds were conducted and no further issues were identify with other tamper alarms for the sprinkler valve located between the water tank and the fire pump, and one located in the sprinkler rising room are providing a supervisory signal at the fire alarm panel when tested. Maintenance Director re-educated that the tamper alarm for the sprinkler valve in front of the intake on the fire pump must provide a supervisory signal at the fire alarm panel when tested. Also all other tamper alarms for the sprinkler valve on the fire pump must provide a supervisory signal at the fire alarm panel when tested.	2/14/12 2/14/12
K 067 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	3. ADMIN/Designee will conduct Quality Improvement monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/Designee will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Completion date 2-14-2012	2/14/12 2/14/12 2/14/12

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DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

(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
K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Tuesday January 10, 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The smoke duct detector intake tube located in the HVAC unit on F-Hall was not properly installed and orientated in the correct direction. 42 CFR 483.70(a)	K 067	K 067 1. The smoke detector intake tube located in the HVAC unit on F-Hall is properly installed and orientated in the correct direction. BFPE re-adjusted the installment of the smoke detector intake tube located in the HVAC unit on F-Hall on 1/11/2012, and the smoke detector intake tube is properly installed in the correct direction. 2. Quality Assurance rounds were conducted to assure that other smoke detector intake tubes were properly installed and oriented in the correct direction. Maintenance Director educated on that the smoke detector intake tube located in the HVAC unit on F-Hall and other locations throughout the facility must be properly installed and oriented in the correct direction. 3. ADMIN/Designee will conduct QI monitoring that egress exit doors release upon activation of the fire alarm. This standard will be monitored 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/Designee will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Completion date 2-14-2012	2/14/12 2/14/12 2/14/12 2/14/12 2/14/12
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Tuesday January 10, 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The smoke damper located in the smoke wall in the attic area on F and C Halls did not close upon activation of the fire alarm system. 42 CFR 483.70(a)	K 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

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K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Tuesday January 10, 2012 between 10:00 AM and 1:00 PM the following was noted: 1) The smoke damper located in the smoke wall in the attic area on F and C Halls did not close upon activation of the fire alarm system. 42 CFR 483.70(a)	K 104	K 104 1. The smoke damper located in the smoke wall in the attic area on F and C Hall closed upon activation of the fire alarm system. Colonial Walls repaired the smoke dampers, and it is properly functioning upon activation of the fire alarm system. Waiver requested for the smoke damper until 3/30/2012. 2. Quality Assurance rounds was conducted to assure that the other smoke dampers located in the attic are properly functioning properly upon activation of the fire alarm system, and no further issues identified. Maintenance Director re- educated that the smoke dampers located in the smoke wall in the attic must close upon activation of the fire alarm system. 3. ADMIN/Designee will conduct QI monitoring that egress exit doors release upon activation of the fire alarm. This standard will be monitored 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. ADMIN/Designee will report results of QI monitoring to the Risk Management Quality Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Completion date 2/14/2012	3/30/12 2/14/12 2/14/12 2/14/12 2/14/12