

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345229	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/16/2012
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - SHELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 159	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review as well as staff interviews, the facility permitted 1 of 3 sampled (Resident #96) residents with trust funds accounts, who received Medicaid benefits, balance to exceed the " within \$200 of the eligibility limit. " The facility did not notify the resident or the family members in this case, as required.</p> <p>The findings included:</p> <p>Upon review of the residents ' personal funds trust account balances on 2/15/12 at approximately 9:15am, Resident #96, a Medicaid recipient, had a balance of \$1,998.95. The limit on personal funds for this resident is \$2,000.00.</p> <p>On 2/15/12 at 9:30am, the Business Office clerk was interviewed to provide information about resident trust</p>		

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The above isolated deficiencies pose no actual harm to the residents

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F 159	<p>Continued From Page 1</p> <p>funds accounts. She stated that they do not notify residents or families when they are within \$200 of the social security (SSI) eligibility limit of \$2,000. She stated that their names are forwarded to the county DSS office for review to determine how the excess funds need to be spent on the resident per Medicaid rules and regulations.</p> <p>On 2/15/12 at 9:40am, the Administrator was interviewed to provide information to ascertain if the Business Office clerk was correct in her statements regarding personal funds. He stated his expectation is that they do notify residents or their families when they are within \$200 of the eligibility limit.</p> <p>On 2/15/12 at 10:00am, the Business Office Manager was interviewed to obtain clarification on the process of notification by the facility of excess funds. She stated that the Business Office clerk forwards her a list each month of those residents who are \$200 within their eligibility limit. She then notifies the resident or their family, whichever is appropriate, of their personal funds account balance being within \$200 of the allowed eligibility limit and the family member or resident will make arrangements to spend down the money according to Medicaid rules and regulations, based on the resident ' s needs. She stated, after discussion with her administrator, she had not notified the family regarding the funds. The resident has had a recent decline in health and so now the daughter is handling her personal funds. The Business Office Manager stated she would notify the daughter today of the account balance and the need for her to spend money from the personal funds account to maintain Medicaid eligibility.</p> <p>On 2/15/12 at 3:30pm, The Business Office Manager presented me a note documenting her phone call to the resident ' s daughter on this date, and advised her of the account balance and the need to spend funds. The daughter stated she had recently bought the resident a few items and needed to be reimbursed for those items. The daughter stated she would be in 2/16/12 to take care of this.</p> <p>On 2/16/12 at 10:15am the Administrator provided a detailed transaction statement for Resident #96 ' s personal funds account. The account detail dated 10/1/11 through 2/7/12 showed the resident ' s balance began with \$1,439.84, up to \$2,828.95 on 2/3/12, that being the highest, and the current balance of \$1,998.95.</p>		
F 356	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. 		

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F 356	<p>Continued From Page 2</p> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <p>o Clear and readable format.</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to include the daily census for 2 of 4 days of survey (2/13/12 and 2/14/12).</p> <p>The findings are:</p> <p>An observation was made of the facility daily staff posting sheet on 2/13/2012 at 1:30PM. The daily staff posting sheet was dated 2/13/2012 and the resident census was noted to be blank.</p> <p>On 2/14/2012 at 9:00AM an observation was made of the facility daily staff posting sheet. The daily staff posting sheet was dated 2/14/2012 and the resident census was noted to be blank.</p> <p>On 2/14/12 at 10:00AM a review was conducted of the daily staff posting sheets for 2/6/2012 through 2/14/2012. The resident census was noted to be blank on the following dates 2/10/2012; 2/12/2012; 2/13/2012 and 2/14/2012.</p> <p>During an interview with the Director of Nursing (DON) on 2/16/2012 at 8:37AM, the DON indicated that the staffing coordinator was responsible for filling out the daily nursing department staffing form and that the third shift nurse was to enter in the census. The DON also stated that she was aware that the census was to be posted on the staffing sheet however the night shift nurse must have forgotten to write the census on the staffing sheet.</p>		

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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and medical record review the facility failed to maintain the dignity of 1 of 5 sampled resident's (Resident #77) by leaving the resident sitting on the side of her bed, exposed with the door open in view of others.</p> <p>The findings included:</p> <p>Resident #77 was admitted to the facility 1/27/12. A review of the most recent full Minimum Data Set (MDS) assessment dated 2/3/2012 revealed; the resident was coded as a 15 on her BIMS (Basic Interview of Mental Status) scale and was coded as needing extensive assistance with dressing. Her diagnoses are hypertension, gastroesophageal reflux disease, renal failure, diabetes, hyperlipidemia and hip fracture.</p> <p>On 02/13/2012 at 11:44 am Resident #77 was observed sitting on the side of her bed in her nightgown, which was pulled up over her hips at waist level. She was wearing underpants. She had no cover over her legs or lower torso and the door to her room was open completely. Resident #77 agreed to an interview at this time. She stated NA (Staff #4) usually helps her get dressed</p>	F 241	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that the alleged deficiencies did, in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the requirements and to provide high quality care.</p>	
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RECEIVED
MAR 12 2012
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kris Thompson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/9/12</i>
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F 241	<p>Continued From page 1</p> <p>and had left her to attend another resident and had not come back. She stated the NA told her that she would be right back. During this interview, the resident was noticed to be pulling at her lap quilt on her bed trying to cover herself. She stated she didn't like being exposed. The resident stated she has to have help getting dressed and she was waiting for the NA to come back. " I am partly blind and have a hard time, " she stated. She also stated she likes getting dressed at 9:30am and it was almost her lunchtime, and she still wasn't dressed. The interview lasted for approximately 20 minutes and the NA (Staff #4) had not come back by the end of the interview. The NA assigned to the resident was interviewed and informed of the resident's present condition. She stated she had gotten " tied up " with another resident.</p> <p>On 2/15/12 at 12:00pm, an interview was conducted with Staff #5 regarding how they assist residents to dress, in line with the residents preferences and likes. Staff #5 stated they try to get the residents up and dressed as close to their desired time as possible and let the resident pick out their clothes. She stated they always shut the doors to the rooms when providing care to give residents their privacy. Staff #5 also stated they keep the residents covered and out of sight from the hall if someone should pass by while care is being given.</p> <p>On 2/15/12 at 2:30pm Staff #1 was interviewed regarding the nurse's expectation of the NA's in their daily care, as far as respecting residents' privacy and dignity. Staff #1 stated that she expected staff to keep the residents covered and out of sight from the hall if someone should pass</p>	F 241	<p>Resident #77 was discharged home February 2, 2012, neither she nor family issued any concerns while a resident in facility.</p> <ul style="list-style-type: none"> • Corrective action has been initiated with regards to other residents having the potential to be affected. In-service with nursing staff on: Federal and State versions of Resident's Rights and F 241 (Dignity), (F164 (Privacy and Confidentiality)) as pertains to giving direct care. Educational handouts of material will be given to staff for personal reference guides. Education to begin March 9, 2012 and completed by March 13, 2012. • To ensure the deficient practice will not recur, the facility staff has developed and put into place audit tools regarding dignity and privacy with staff education. • Monitoring for corrective performance will be accomplished by: audits done by appointed department managers and staff to observe for any infractions involving resident dignity, privacy or rights. Audits to be performed daily on all shifts for two weeks then weekly for a month. Audits to begin March 9, 2012 and end April 30, 2012. Reports and audits findings to be monitored monthly by the Quality Assurance Committee with necessary changes being made. 	03/13/12
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F 241	Continued From page 2 by while providing care to the residents. On 2/16/12 3:00pm an interview was conducted with the Director of Nursing (DON). During this interview, the DON stated that she expected all staff to keep residents covered and out of sight from others during care.	F 241		
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 resident and staff interviews and record reviews the facility failed to develop a comprehensive care plan for two (2) out of twenty (20) sampled residents. (Resident #138 and #1)	F 279	<ul style="list-style-type: none"> For resident #138 and #1, the care plan was reviewed and updated as appropriate. For other residents with the same potential to be affected: resident comprehensive care plans and resident care sheets are updated in a timely manner and are accurate in describing the resident's current status. Measures put into place have been: staff in serviced on March 9, 2012 on the components of the care plan process and timeliness. In-services will be completed by March 13, 2012. An audit form for care plan accuracy and content will be performed for twelve weeks. Monitoring for compliance will be accomplished with an audit tool that includes components of the care plan process. Auditing of ten care plans weekly for twelve weeks will be performed by the Director of Nursing and Assistant Director of Nursing. Results will be reviewed monthly by the Quality Assurance Committee with any necessary changes being made. 	03/13/12

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F 279	<p>Continued From page 3</p> <p>The findings included:</p> <p>1. Resident #138 was admitted on 11/01/2011 with a diagnosis of Dementia; hypertension and diabetes. An admission Minimum Data Set (MDS) assessment dated 11/9/11 indicated cognitive impairment with no mood or behaviors. A quarterly MDS dated 2/1/12 indicated cognitive impairment with no moods noted but documented physical and verbal behaviors; other behavioral symptoms as well as rejection of care approximately one to three days a week. The MDS also indicated wandering one to three days a week.</p> <p>A review of the plan of care for Resident #138 dated 2/6/12 did not address behaviors.</p> <p>A review of Resident #138's behavior problem documentation sheet for 1/26/12 through 2/1/12 documented the resident as exhibiting physical behaviors on 1/27/12; verbal behaviors on 1/27/12 and 1/31/12; other behavioral symptoms not directed toward others on 1/26/12, 1/27/12, 1/31/12 and 2/1/12; wandering behaviors on 1/27/12, 1/31/12 and 2/1/12 and resisting care behavior on 1/31/12.</p> <p>A nursing note dated 1/27/12 noted Resident #138 to be wandering, resistive to care and unable to recognize her husband.</p> <p>A review of Resident #138's resident care information sheet noted under mental status/behaviors that Resident #138 was confused and forgetful with no documentation of resistance to care or combative/verbally abusive</p>	F 279			

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F 279	<p>Continued From page 4 behavior.</p> <p>During an interview with nursing assistant (NA) #2 on 2/15/12 at 10AM, NA #2 explained that Resident #138 had a change in behavior within the last month. The resident was more confused and within this last week the resident no longer recognized or remembered her husband. NA #2 also stated that the resident has been refusing to go to the dining room due to not wanting to run into that "boy."</p> <p>During an interview with licensed nurse (LN) #1 on 2/15/12 at 10:30AM, LN #1 explained that resident #138 was having more verbal behaviors; had been hard to redirect; had been more hostile and aggressive with her husband and did not recognize him. The LN also stated that the husband was moved to the opposite hall to prevent them from bumping into each other, because Resident # 138 would say that she did not marry him and why was " that boy " in her room. The LN further reported that yesterday Resident #138 was taken to the dining room and that the NA seated Resident #138 with her husband The LN reported that Resident #138 became upset and had to be assisted out of the dining room. The LN also reported that Resident #138 was upset to the point that the resident slammed her hand on the nurse's station counter after being removed from the dining room and seeing who Resident #138 referred to as " that boy" in the dining room.</p> <p>During an interview with MDS nurse #2 on 2/15/12 at 4:55PM, the MDS nurse revealed that she completed Resident #138's MDS dated 2/1/12 and coded the MDS with behaviors. The</p>	F 279			

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F 279	<p>Continued From page 5</p> <p>MDS nurse also stated that at that time she should have initiated a plan of care for behaviors.</p> <p>During an interview with the Director of Nurses (DON) on 2/16/12 at 8:42AM, the DON stated that her expectation is that the plan of care would have addressed the behaviors, since it was a change in Resident #138's condition.</p> <p>2. Resident #1 was admitted with diagnosis of neurological disorder, a muscle spasm, limited range of motion, speech impairment, and requires extensive assistance in his Activities of Daily Living (ADL) ' s. He is a long term resident of the facility, alert and oriented and able to make decisions for himself.</p> <p>On 02/13/2012 at 12:00pm an observation of Resident #1, revealed him sitting in his specialty geri chair in his room watching television. He had contracture's in both hands and arms and his right leg, which were visible to me. Noted on his chart was documentation of Physical Therapy and Occupational Therapy consults and records of interventions.</p> <p>On 2/13/12 at 3:30pm after review of the resident's chart, no care plan was identified for Range of Motion (ROM) exercises or the splint.</p> <p>On 2/15/12 at 4:00pm Physical Therapy (PT) and Occupational Therapy (OT) staff verified they had assessed him and orders were written for resident to have a splint and ROM, but resident consistently refuses. Resident #1 also refuses</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>other areas of care, such as weights and vital signs and that is documented by nursing staff. He had been referred to restorative services, but no documentation was found on restorative notes concerning ROM or splint use.</p> <p>On 2/16/12 at 9:00am Resident #1 was interviewed regarding his ROM exercises and his splint. He stated he refused to wear the splint because it causes swelling and pain. He states the exercises are uncomfortable as well. He stated he is going to speak to his doctor at his next visit about another type of splint.</p> <p>On 2/16/12 at 11:30am the ADON, in an interview, indicated the facility was unable to locate the orders to discontinue the splint and ROM exercises.</p> <p>On 2/16/12 at 12:00pm the DON was interviewed regarding Resident #1. The DON indicated the resident should have a care plan on ROM and splint use, along with interventions concerning his continuous refusal and follow up regarding physician orders addressing this issue.</p>	F 279			