STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BLDG _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY MEDICAL CENTER	4130 US HWY 64 EAST MURPHY, NC 28906

(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	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 medical record review and staff interviews the facility failed to implement standing orders for constipation for one (1) of ten (10) residents (Resident #50). The findings are: Resident #50 was admitted to the facility with Alzheimer's Disease. The latest Minimum Data Set (MDS) dated 03/19/12 revealed the resident was unable to be assessed for memory due to communication problems but was assessed as severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident was always incontinent of bowel and required total assistance with toileting. The care plan for Resident #50, dated 04/04/12, revealed the resident was at risk for constipation. Interventions included administering of bowel meds as ordered, monitoring for effectiveness of medications, and reporting problems to the physician. Review of the physician orders revealed the	F 309	• Corrective action has been accomplished for this resident by monitoring for usage of the bowel protocol. The Bowel movement (BM) protocol has been followed for this resident, as verified by record review. Prune juice has been added to each of her meal trays and this intervention was added to the care plan. MD orders were obtained to increase Senna S to (2) tabs twice per day. Hall staff were educated to monitor and document bowel movements, and to follow the bowel protocol. • Corrective action will be accomplished for those residents who have the potential to be affected by the same deficient practice by re-educating all direct care staff at the 6/1/12 staff meeting by the DON, on proper monitoring and documentation of resident's bowel activity. Nurses will be re-educated at the 6/1/12 staff meeting by the DON, to print out the list of resident's who have not had a BM in the last 72hours, and to follow the bowel protocol. • Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur include nurses will be instructed by the DON at the 6/1/12 staff meeting to no longer fill in the results section of Medication Administration Record (MAR) with "pending". This section should only be filled in after the resident has had a result. Education regarding BM protocol will be provided on an annual basis via Health Stream staff development tool and during orientation process by LTC staff development for new employees.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Moody | TITLE: administrator | (X6) DATE: 05/25/12

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.

MAY 29 2012
BY:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 1 physician had written an order on 06/16/06 for Senna S (a laxative) to be administered twice a day. Review of the Medication Administration Record (MAR) revealed the resident was receiving the medication as ordered. Further review of the medical record revealed the resident had no history of bowel impaction. The facility physician standing orders for all residents were reviewed. These orders included administration of Milk of Magnesia (MOM) every other day as needed for constipation. The standing orders further specified that for no bowel movement (BM) results within 24 hours, a 10 mg bisacodyl suppository should be administered. If no results within 24 hours, a sodium phosphates enema should be administered. A review of the medical record for Resident #50 revealed the Resident Bowel and Bladder by Shift Chart which documented the frequency of BMs. A review of this chart as well as the MAR revealed the following documentation: On 12/12/11 the resident had a BM and did not have another BM until nine days later on 12/21/11. She received MOM on 12/16/11 and a bisacodyl suppository on 12/18/11. On 01/01/12 the resident had a BM and did not have another BM until six days later on 01/06/1 2. She did not receive any additional bowel medication during this time. On 01/19/12 the resident had a BM and did not have another BM until eight days later on 01/22/12. She received MOM on 01/22/12.	F 309	• The facility plans to monitor its performance to make sure that the solutions are sustained by having the Charge nurse review and record on the BM list for his/her shift the interventions or results reported to him/her by the hall nurse for each indicated resident. Charge nurse will provide report to DON with interventions indicated on it for every shift. These reports will be reviewed by DON, ADON, Administrator or designee for appropriateness of actions taken and any inappropriate follow up by staff will be addressed with employees on an individualized basis. Results of these audits will be reported at the monthly Performance Improvement (PI) meeting and the weekly safety meeting for 3 months and longer if indicated. PI committee will implement a plan of correction for any identified problem areas. • Corrective actions will be completed by 6/4/2012	

F 309	Continued From page 2 On 02/20/12 the resident had a BM and did not have another BM until nine days later on 02/28/12. She received MOM on 02/23/12. On 04/22/12 the resident had a BM and did not have another BM until six days later on 04/28/12. She received MOM on 04/27/12. On 04/28/12 the resident had a BM and did not have another BM until five days later on 05/03/12. She did not receive any additional bowel medication during this time. On 05/10/12 at 10:18 AM, Licensed Nurse (LN) #1 was interviewed. She stated that a list was compiled daily of residents who have gone 72 hours (three days) or greater without a BM. The nurses would administer MOM to anyone on that list each day. If no results were obtained within 24 hours, the nurses would administer a bisacodyl suppository. If no results were obtained within 24 hours, the nurses would administer a sodium phosphates enema. If no results were obtained, the physician would be notified. On 05/10/12 at 1:41 PM, the Director of Nursing (DON) was interviewed. She stated that the facility physician standing orders for constipation should be initiated after no BM for three days. She examined the Resident Bowel and Bladder by Shift Chart for Resident #50 and stated that in each instance noted above, the resident should have received MOM after three days, and if no results were obtained the rest of the facility bowel protocol in the physician standing orders should have been initiated.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 3 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, facility and medical record review, and staff interviews, the facility failed to clean fingernails and remove facial hair for three (3) of seven (7) sampled residents dependent on staff for assistance with personal hygiene (Residents #197, 116, and 103). The findings are: 1. Resident #197 was admitted to the facility with dementia. Review of the medical record revealed the initial Minimum Data Set (MDS) was not finalized. On 05/10/12 at 2:47 PM the MDS Coordinator was interviewed. She reported Resident #197 required staff assistance with grooming related to his dementia. On 05/10/12 at 3:06 PM the resident's nurse, Licensed Nurse #1, was interviewed. She stated Resident #197 was unable to clean his own fingernails due to dementia and poor eyesight. She stated he would require a staff member to clean his fingernails for him. A review of the resident's interim admission care plan revealed that activities of daily living (ADL)	F 312	• Corrective actions were accomplished for those residents found to have been affected by the deficient practice as evidenced by hall staff on 5/10/12 cleaned the fingernails of resident # 197 and were instructed by ADON to monitor them closely. Corrective actions were accomplished for residents #116 and #103 by staff shaving the residents. Staff was instructed by ADON to monitor for facial hair and shave as needed. • Corrective action will be accomplished for those residents who have the potential to be affected by the same deficient practice by providing each hall with a nail care kit/basket and electric razor. On 5/21/12 ADON performed a visual inspection of all residents and any needed grooming interventions were performed by hall staff. Education will be provided by the DON at the 6/1/12 staff meeting to all staff regarding location of these tools and expectations of use. • Measures and systemic changes made to ensure that the deficient practice will not occur include each resident with facial hair will be issued their own razor head. Electronic documentation will include residents nail care and shaving to be charted on daily. Each hall will be provided a nail care kit/basket, and an electric razor. All staff will be educated by the DON at the 6/1/12 staff meeting regarding ADL's and good grooming. Education regarding ADL's and good grooming of dependent residents will also be provided on an annual basis via Health Stream staff development tool and during orientation process by LTC staff development for new employees.	

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F 312	Continued From page 4 were addressed. The care plan problem noted the resident required assistance with all ADL due to dementia. The goal indicated the resident would have a clean, well groomed appearance. One intervention was for staff to provide all the assistance the resident needed for ADL. On 05/07/12 at 4:25 PM Resident #197 was observed in his room. All finger and thumb nails on both hands had copious black matter beneath the nails. On 05/08/12 at 11:00 AM Resident #197 was again observed in his room with his nails in the same condition as above. On 05/09/12 at 10:15 AM Resident #197 was observed in his room. All his fingernails appeared to be clean. On 05/09/12 at 3:00 PM Nursing Assistant (NA) #1 and NA #2, both of whom worked on the resident's hall, were interviewed together. They stated the resident did not refuse any care from them. They stated that the shower team cleaned the resident's fingernails on his shower days, Tuesday and Friday, and they were responsible for cleaning them in between showers if they needed it. NA #2 stated she had worked with Resident #197 on 05/08/12 and had not noticed any problem with his fingernails. On 05/10/12 at 9:53 AM NA #4, a member of the facility shower team, was interviewed. She stated she was responsible for cleaning fingernails of residents on their shower day, but that the hall NAs were responsible for cleaning fingernails in between showers if they needed cleaning. She	F 312	• The facility plans to monitor its performance to make sure that solutions are sustained by requiring the bath team members to report to the hall nurse if they discover any problems related to nail care and/or facial hair at the time of discovery. Administrative staff will perform a visual inspection of residents on a weekly basis and will report dirty nails and facial hair to hall staff for correction. Monitoring form will be turned in to Administrator. Results will be reported in monthly PI meeting for 3 months and longer if indicated. PI committee will implement a plan of correction for any identified problem areas. • Corrective action will be completed by 6/4/2012	

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F 312	Continued From page 5 stated there was black matter under all of Resident #197's fingernails when she showered him on 05/08/12 and cleaned his nails. She stated they were always dirty on shower day, so she mentioned this to the hall NAs so they would monitor his nails between showers. She stated she had not talked to the resident's nurse about the dirty nails. On 05/10/12 at 2:10 PM the Director of Nursing was interviewed. She stated she expected the shower team and the hall NAs to monitor and clean fingernails as needed. She stated she would have expected that Resident #197s nails would have been monitored and cleaned between showers. 2. Resident #116 was admitted to the facility with diagnoses including Epilepsy, Organic Brain Syndrome, Aphasia, and Alzheimer's Disease. On the most recent Minimum Data Set (MDS), a quarterly dated 04/05/12, Resident #116 was assessed as having long and short term memory problems, severely impaired cognition for daily decision making, and totally dependent on staff for personal hygiene and bathing. The care plan, updated 04/11/1 2, revealed Resident #116 was usually non-verbal, had difficulty communicating and required extensive to total assistance from staff for activities of daily living (ADLs). Care plan goals and interventions included anticipation of needs and provision of ADL assistance to maintain a clean, well groomed appearance. On 05/08/12 at 10:25 AM Resident #116 was observed in the residents' common area with	F 312		

345190	G B WNC	05/10/2012

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F 312	Continued From page 6 numerous white facial hairs approximately one-fourth (1/4) inch long scattered over her entire chin. The facial hair remained present during subsequent observations: 05/09/12 at 8:30 AM and 11:50 AM 05/10/12 at 9:15 AM and 10:15 AM During an interview on 05/10/12 at 9:25 AM Nursing Assistant (NA) #3 observed Resident #116 and confirmed the presence of facial chin hair. NA #3 revealed NA staff were responsible for removing residents' facial hair weekly during baths/showers and daily with ADL care as needed. The interview revealed Resident #116 was bathed/showered 05/09/12 and her facial hair should have been removed. NA #3 stated she would have removed the resident's facial hair this morning had she noticed it during ADL care. During an interview, 05/10/12 at 10:40 AM, the Director of Nursing (DON) stated NA staff were expected to remove residents' facial hair weekly during baths/showers and daily with ADL care as needed. The DON further revealed Licensed Nursing (LN) staff were responsible for supervising NA staff and ensuring that residents' facial hair was removed as needed. 3. Resident # 103 was admitted to the facility with diagnoses including Alzheimer's Disease. On the most recent Minimum Data Set (MDS), a quarterly dated 04/02/12, Resident #103 was assessed as having long and short term memory problems, severely impaired cognition for daily decision making, and totally dependent of staff for personal hygiene and bathing. The care plan, updated 04/10/12, revealed	F 312		

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F 312	Continued From page 7 Resident #103 had difficulty communicating and required extensive to total assist from staff for activities of daily living (ADLs). Care plan goals and interventions included anticipation of needs and provision of ADL assistance to maintain a clean, well groomed appearance. On 05/08/12 at 1:25 PM Resident #103 was observed in the residents' common area with six to eight facial hairs approximately one-fourth (1/4) to one-half (1/2) inch long on her left chin. Several hairs were black in color and curling upward on the resident's face. The facial hair remained present during subsequent observations: 05/09/12 at 8:30 AM and 11:50 AM 05/10/12 at 9:15 AM and 10:15 AM During an interview on 05/10/12 at 9:25 AM Nursing Assistant (NA) #3 observed Resident #103 and confirmed the presence of facial chin hair. NA #3 revealed NA staff were responsible for removing residents' facial hair weekly during baths/showers and daily with ADL care as needed. The interview revealed Resident #103 was bathed/showered 05/08/12 and her facial hair should have been removed. NA #3 stated she would have removed the resident's facial hair this morning had she noticed it during ADL care. During an interview, 05/10/12 at 10:40 AM, the Director of Nursing (DON) stated NA staff were expected to remove residents' facial hair weekly during baths/showers and daily with ADL care as needed. The DON further revealed Licensed Nursing (LN) staff were responsible for supervising NA staff and ensuring that residents' facial hair was removed as needed.	F 312		
