STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345459	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATES	619 LAUREL LAKE DR COLUMBUS, NC 28722

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to test stool for blood for one (1) of one (1) sampled resident. (Resident #16) The findings are: Resident #16 had diagnoses which included deep vein thrombosis. Resident #16 had a problem area on her current care plan dated 2/6/12, "Prone to bleeding related to Coumadin (a medication used to thin blood) usage." Approaches to address this problem included: Coumadin as ordered, Labs as ordered, Monitor for increased bruising or active bleeding and report to physician/nurse practitioner as needed. Resident #16 was assessed on the quarterly assessment dated 4/10/12 with moderate cognitive impairment. Review of physician orders in the medical record of Resident #16 revealed a telephone order on 4/5/12 to check stool for occult (the presence of) blood for three days. Further review of the medical record of Resident #16 revealed the resident's stools had not been checked for occult blood. The medical record of Resident #16 revealed a nurses note dated 4/5/12 at 3:33 PM by licensed	F 281	A stool hemoccult which was negative was obtained on the resident identified in the survey process prior to surveyors leaving the facility. The nurse practitioner was notified of the results and delay in obtaining the hemoccult. Other residents will be reviewed for stool hemoccult orders to assure they have been obtained as ordered. To prevent further occurrences of delays in obtaining stool hemocculs which	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dionne M James — TITLE: Administrator — (X6) DATE: 5/31/12

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.

RECEIVED
JUN 04 2012
BY:

Original Signature Date: 5-29-12

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F 281	Continued From page 1 nurse (LN) #2 which noted labs (including hemoglobin and hematocrit) were called to the nurse practitioner and the nurse practitioner gave a telephone order to check stool for occult blood for three days. On 5/9/12 at 3:55 PM LN #2 stated she remembered talking to the nurse practitioner and received the telephone order to check stools for occult blood for three days. LN#2 stated she would have written the need to check stool for occult blood on the nursing clipboard. LN#2 stated she would have asked the nursing assistants to place a "hat" (a disposable container used to collect urine/stool samples) in the resident's bathroom to obtain a stool sample. LN#2 stated she worked with Resident #16 very little since 4/5/12 and, because of this, could not explain why the test was not done. LN#2 reviewed the April 2012 Medication Administration Record (MAR) for Resident #16 and noted she had also written the need to check stool for occult blood on the April MAR. LN#2 verified all dated entries beside this notation on the resident's April MAR were blank. Review of nursing notes in the medical record of Resident #16 revealed only one entry regarding the need to check stools for occult blood. This note was written by LN #3 on 4/7/12 at 12:52 PM, "Hats were placed in resident's toilet to obtain stool sample. Nursing assistant stated that resident had took them out and said, oh those are not for me. Unable to obtain sample." On 5/9/12 at 3:25 PM LN#3 stated she reviewed the nursing clipboard to identify resident needs at the beginning of every shift. LN#3 stated she remembered Resident #16 removed the "hat" from the commode on 4/7/12 so a stool sample was not obtained. LN#3 stated she had worked	F 281	are performed in house , we have developed a form for recording the results of a stool hemoccult. This form will be initiated when a hemoccult is ordered by the nurse receiving the order. Certified Nursing assistants will be assigned on the assignment/vital signs sheet to notify floor nurse when resident has a bowel movement. Nurse will record on the new form. If the stool hemoccult has not been obtained within 1 week due to a resident refusal, the physician or nurse practitioner will be notified.	

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F 281	Continued From page 2 with Resident #16 since that time and could not explain why other attempts were not made to check stool samples. LN#3 verified the notation to check stool for occult blood for three days remained on the nurses clipboard as a current need for Resident #16. LN #3 stated on 5/9/12 (after the omission was brought to the attention of staff) she checked a stool sample for Resident #16 and the negative results (as well as the delay in testing) were reported to the nurse practitioner. On 5/9/12 at 3:45 PM LN#4 stated she had worked with Resident #16 several times since 4/5/12. LN#4 verified the need to check stools for occult blood was on the nursing clipboard as well the April and May 2012 MAR of Resident #16. LN#4 stated Resident #16 frequently took herself to the bathroom and flushed the toilet without informing staff if she had a bowel movement. LN #4 stated she reviewed the nursing clipboard prior to every shift to identify any needs and couldn't explain why stools for Resident #16 had not been checked for occult blood. On 5/10/12 at 12:05 PM nursing assistant (NA) #1 stated she was very familiar with Resident #16 as she often worked with her. NA#1 stated nurses would inform her to put a "hat" in a residents bathroom if there was a need for a urine or bowel sample. NA#1 stated she did not recall being asked to place a "hat" in the bathroom of Resident #16 in the past month. NA#1 stated that although Resident #16 could toilet independently she "pretty much knew her schedule" and could have reminded Resident #16 to use the "hat" so a stool sample could have been obtained.	F 281	The nurse receiving the stool hemoccult order will notify the ADON and DON. They will monitor to assure the stool hemoccult is obtained as ordered. This new process will be reviewed quarterly during the QA meeting with a list of resident's with orders for stool hemoccults and dates obtained. The staff will have completed inservice training on this new process by June 12, 2012.	June 12, 2012

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F 281	Continued From page 3 On 5/9/12 at 2:10 PM the Director of Nursing (DON) stated when a physician/nurse practitioner ordered to check stool for occult blood this would be done by nurses at the facility. The DON stated a "hat" would be placed in the bathroom of a resident to obtain a sample for the test. The DON stated the need for the test would be placed on the nursing clipboard. The DON stated the clipboard is the communication tool used by nurses every shift to document specific resident needs. The DON stated she would expect nurses to note on the clipboard if they were able to check a stool sample so oncoming nurses would know how many additional samples needed to be checked. The DON reviewed the nursing clipboard and medical record of Resident # 16 and stated the resident's stool had not been checked for occult blood. The DON stated the need to check stools for occult blood for Resident #16 remained on the nursing clipboard and she would have expected nursing staff to complete the test as ordered.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to removed facial hair for two (2) of eight (8) sampled female residents dependent on staff for personal care.	F 312		

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F 312	Continued From page 4 (Resident #12 and #30) The findings are: 1. Resident # 12 had diagnoses including heart disease and anxiety disorder. Review of the significant change Minimum Data Set (MDS) dated 3/21/12 revealed moderately impaired cognition and extensive assistance required for personal hygiene. The MDS also revealed no rejection of care or other behaviors. On 5/8/12 at 8:45 a.m., Resident #12 was observed with multiple hairs scattered across her chin. The hairs were light-colored and approximately 1/8 inch (") in length. On 5/9/12 at 4:35 p.m., Resident #12 was observed in her room talking with her personal sitter. Multiple, light-colored hairs approximately 1/8" in length were observed scattered across Resident #12's chin. When asked about the presence of the chin hairs, Resident #12 stated, "It definitely bothers me. I don't like it." Interview at that time with the personal sitter revealed she did no personal hygiene care for Resident #12. On 5/10/12 at 9:20 a.m., Resident #12 was observed with multiple hairs scattered across her chin. Review of the shower schedule revealed Resident #12 received showers on the evening shift on Mondays and on the day shift on Fridays. Interviews were conducted with the two Nursing Assistants (NA) who provided care to Resident #12 on 5/10/12. During an interview on 5/10/12	F 312	The female residents identified in the survey had the facial hair removed by the CNA's before the surveyors left the facility. One resident did not desire to have her facial hair removed. This has been added to her care plan. Other female residents were checked for excessive facial hair. To prevent further occurrences of facial hair, the CNA's have been assigned to trim facial hair of women on bath days. This is noted on the bath schedule. The charge nurse will	

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F 312	Continued From page 5 at 9:35 a.m., NA #1 revealed the nursing assistants' responsibilities included nail care and removing facial hair for female residents. NA #1 said Resident #12 was shaved "every once in awhile" but she did not have a lot of facial hair and until recently, she had used tweezers to remove her own chin hairs. Interview with NA #2 on 5/10/12 at 9:40 a.m. revealed NAs were supposed to remove facial hair for female residents whenever it was visible. During an interview on 5/10/12 at 9:55 a.m., Licensed Nurse (LN) #1 said if the residents would allow it to be done, female residents should be shaved during their bathing time. Interview with the Director of Nursing (DON) on 05/10/12 at 1:15 PM revealed nursing assistants (NAs) are expected to remove female residents' facial hair as needed on shower days. 2. Resident #30 had diagnoses including Non-Alzheimer's Dementia. A quarterly Minimum Data Set (MDS) completed 04/10/12 revealed Resident #30 had severely impaired cognition and required limited assistance with with personal hygiene. Rejection of care was not noted during the 7-day look back period for the quarterly MDS. A Care Area Assessment (CAA) Summary for activities of daily living (ADLs) function completed on 11/08/11 stated Resident #30 required limited to extensive assistance with ADLs. The CAA Summary further stated Resident #30's general weakness and Dementia interfered with her ability to perform ADLs.	F 312	monitor to assure the facial hair has been trimmed on female residents. If a resident or family requests facial hair not be trimmed it will be added to their care plan. The staff will receive inservice training by 6-12-12. The charge nurse will monitor the resident during weekly body audits to assure facial hair is trimmed or noted on the care plan. Monthly rounds by supervisor will include review of facial hair and information will be forwarded to the QA meeting for review on a quarterly basis.	June 12, 2012

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F 312	Continued From page 6 A care plan, last reviewed on 04/17/12, stated Resident #30 required assistance with ADLs due to general weakness and weakness from a right hip fracture. The intervention was to assist with ADLs as needed. Review of the shower schedule revealed Resident #30 received showers every Tuesday and Friday on the 7:00 AM to 3:00 PM shift. Observations of Resident #30 on 05/08/12 at 9:58 AM revealed multiple chin hairs, 1/4 inch (") to 1/2" in length, scattered across her chin. A subsequent observation on 05/09/12 at 10:00 AM revealed multiple chin hairs, 1/4" to 1/2" in length, scattered across her chin. On 05/10/12 at 9:37 AM, Resident #30 was observed while sitting in her room reading the newspaper. Multiple chin hairs, 1/4" to 1/2" in length, were noted scattered across her chin. An interview with the Director of Nursing (DON) on 05/10/12 at 1:15 PM revealed nursing assistants (NAs) are expected to remove female residents' facial hair as needed on shower days. The DON observed Resident #30's chin hairs at the completion of the interview and asked an NA to take Resident #30 to her room and ask for permission to remove the facial hairs. During an interview on 05/10/12 at 1:45 PM NA #1 confirmed she cared for Resident #30 frequently and had assisted her with ADLs on 05/10/12 but did not notice the length of her chin hairs. NA #1 further stated she usually checked female residents for facial hair on shower days and plucked or shaved depending on the	F 312		

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

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F 312	Continued From page 7 residents preference.	F 312		