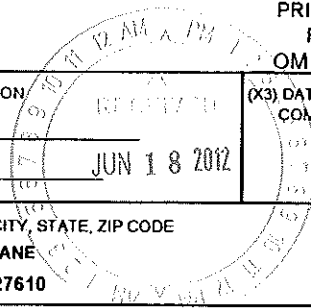


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/05/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/31/2012
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NAME OF PROVIDER OR SUPPLIER CAPITAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3000 HOLSTON LANE RALEIGH, NC 27610
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322 SS=E	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer product recommendations and staff interviews the facility failed to maintain gastrostomy supplies by; 1) The facility failed to follow manufacturer recommendations to dispose of single use gastrostomy tube decloggers for 4 of 4 sampled residents (resident #3, #6, #7 and #8) and 2) The facility failed to recap or protect the distal end of feeding delivery tubing while disconnected from 2 of 2 sampled residents (resident #3 and #6).</p> <p>Findings include: On 5/30/12 at 11:59 AM resident #3's feeding pump dial was observed in the off position and the distal end of the feeding delivery tubing was draped over the back of the feeding pump uncapped and unprotected. Following wound care nurse #1 reconnected the distal end of the feeding delivery tubing to resident #3's gastrostomy tube (g-tube) and resumed the feeding. A clear, opened package was secured vertically to resident #3's bulletin board. Inside the clear package was a g-tube declogger with dried</p>	F 322	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>Corrective Action for Resident Affected Residents # 3, 6, 7, 8 the decloggers were removed on 5/30/12. Residents # 3 and 6 G Tubes were capped when the distal end of the feeding delivery tube was disconnected.</p> <p>Corrective Action for Resident Potentially Affected All residents with G Tubes have the potential to be affected by this alleged deficient practice. Residents were reviewed by the DON on 5/31/12 to ensure that there were no Gastrostomy Decloggers at bedside and that caps were available for G Tubes when disconnected and used as appropriate.</p> <p>Systemic Changes An in-service was conducted on the following dates: May 30th, 31st, June 8th, June 13th. Those who attended all RNs, LPNs, FT, PT, and PRN Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Do not use decloggers more than one time with our g-tubes, review of how to use other alternatives for declogging tubes such as gentle massage and flushing with warm water, if it is still clogged, replace the tube, also discussed capping the tube when disconnected to ensure no contamination. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>Quality Assurance The Director of Nursing or Assistant Director of Nursing or RN Staff Development Coordinator will monitor this issue using the "Survey QA Tool for G Tubes". The monitoring will include verifying that there are no used decloggers at bedside and that caps are available for recapping/protecting the distal end of the feeding delivery tube when disconnected. All residents with G Tubes will be reviewed. See attached mentoring tool. This will be done daily Monday thru Friday for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate.</p> <p>The facility will have all items completed by June 15th 2012.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Amy S. Hinely

TITLE

Administrator

(X6) DATE

6/15/2012

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 322	<p>Continued From page 1</p> <p>brownish green material noted on the declogger and smeared along the entire length of the package. In the bottom of the package approximately two centimeters of brownish green material was noted. The back of the package noted the name of the product as an "Enteral Feeding Tube DeClogger" and under "Precautions" read; "The DeClogger is intended for single use only and does not require sterilization."</p> <p>On 5/30/12 at 12:16 PM resident #6's feeding pump dial was observed in the off position and the distal end of the feeding delivery tubing was draped over the back of the feeding pump uncapped and unprotected. Following wound care nurse #1 reconnected the distal end of the feeding pump tubing to resident #3's g-tube and resumed the feeding. A clear, opened package was secured vertically to resident 6's bulletin board. Inside the package was a declogger with dried brownish green material noted on the declogger and smeared along the entire length of the package. In the bottom of the package approximately one and a half centimeters of brownish green material was noted. The back of the package noted the name of the product as an "Enteral Feeding Tube DeClogger" and under "Precautions" read; "The DeClogger is intended for single use only and does not require sterilization."</p> <p>On 5/30/12 at 3:05 PM resident #7 had a clear, opened package secured vertically to her bulletin board. There were two decloggers with dried light brown material noted on both of the decloggers. The back of the package noted the name of the product as an "Enteral Feeding Tube DeClogger"</p>	F 322			

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F 322	<p>Continued From page 2</p> <p>and under "Precautions" read; "The DeClogger is intended for single use only and does not require sterilization."</p> <p>On 5/30/12 at 3:10 PM resident #8 had a clear, opened package secured vertically to his bulletin board. Inside the clear package was a declogger with dried brownish green material noted on the declogger and smeared along the entire length of the package. In the bottom of the package approximately one and a half centimeters of brownish green material was noted. The back of the package noted the name of the product as an "Enteral Feeding Tube DeClogger" and under "Precautions" read; "The DeClogger is intended for single use only and does not require sterilization."</p> <p>On 5/30/12 at 2:55 PM nurse #2 stated she did not stop or unhook the tube feedings for residents #3 or #6. Nurse #2 was able to verbalize steps of stopping and disconnecting a continuous feeding and indicated that the distal end of the feeding pump tubing should be re-capped when disconnected. Nurse #2 said she has not used decloggers in the facility and verbalized alternate methods she would use if a gastric tube would not flush. She indicated that both residents' g-tubes flowed without difficulty to her knowledge. Nurse #2 stated that if a declogger was used it should be disposed of after use because it was a single use item. Nurse #3 indicated she was trained upon hire by the staff development coordinator on g-tube care but could not recall specifically being trained on the use of decloggers.</p> <p>On 5/30/12 at 3:12 PM nurse #3 was able to</p>	F 322			

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F 322	<p>Continued From page 3</p> <p>verbalize the steps of disconnecting a continuous feeding and indicated the distal end of the feeding pump tubing should be capped and protected when disconnected from a resident. Nurse #3 stated she used decloggers in the facility occasionally and that when a declogger was used it was to be wiped off and placed back in the package and kept in the resident's room for the next use. She said she only discarded a declogger if it was bent. Nurse #3 indicated she was trained by the staff development coordinator upon hire approximately one year ago on g-tube care. She could not recall that she was specifically trained on the use of decloggers.</p> <p>On 5/30/12 at 3:18 PM nurse #1 said she unhooked resident #3 and #6 from their continuous tube feeding for wound care. Nurse #1 was able to verbalize the steps of disconnecting a continuous feeding and indicated that whenever a feeding was disconnected from a resident the distal end of the feeding delivery tubing should be recapped. When nurse #1 was told that both resident #3 and #6's tubing had not been capped or protected she stated she thought she was nervous and had forgotten to recap the tubing.</p> <p>On 5/30/12 at 3:22 PM the Director of Nursing (DON) indicated she expected the distal end of a residents feeding delivery tubing to be recapped or protected when disconnected. She also expected that decloggers would not be used in the facility. The DON verbalized that the decloggers were a single use item and should have been discarded and not secured to the bulletin boards. She indicated that the staff development coordinator trained staff on g-tube</p>	F 322			

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F 322	Continued From page 4 care upon hire and annually. On 5/30/12 at 3:28 PM the Staff Development Coordinator (SDC) said her expectation was for the nursing staff to follow the policy and procedure for g-tube care per facility standards. She said it was the expectation of the staff to cap the distal end of the feeding delivery tubing whenever it was disconnected from a resident. She indicated there was no policy or procedure for the use of decloggers and she would expect staff that has been trained to use a declogger to follow the manufactures package guidelines and she would expect any staff not trained to use a declogger to avoid the use of one. The SDC said nurses are trained on g-tube care upon hire and annually and perform a return demonstration to verify competency.	F 322			