STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING ______ B. WING ______	C 05/02/2013

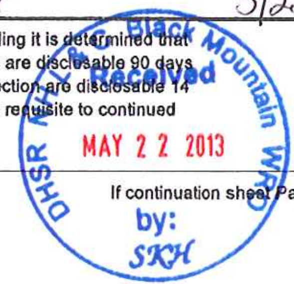
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYSTONE HEALTH & REHABILITATION	80 BROWNSBERGER CIRCLE FLETCHER, NC 28732

(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 000	INITIAL COMMENTS No deficienciences were cited as a result of the complaint investigation. Event ID # KE7711.	F 000	Beystone Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is May 24, 2013. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.	
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, facility bowel records and staff interviews the facility failed to monitor for and administer medication for constipation for 1 of 10 residents reviewed for constipation. The findings included: Resident #36 was admitted to the facility with diagnoses which included schizoaffective disorder and Parkinson's disease. Review of Resident #36's most recent Quarterly Minimum Data Set (MDS) dated 04/09/13 revealed she was cognitively intact. The MDS indicted Resident #36 was always incontinent of bowel and bladder. Review of bowel records revealed Resident #36 did not had a bowel movement from 04/03/13 through 04/09/13. Review of physician orders dated for the month of	F 309	F 309 Resident #36 chart was reviewed, the system was reviewed, and an investigation was completed to determine breakdown of systems. Staff were in-serviced/disciplined as deemed necessary by the Director of Nursing (DON) and Administrator. The bowel charting and alerts where audited by the DON on 5/2/13 to identify any resident that had gone three days without a bowel movement. The Clinical Care Coordinator interviewed all residents that are alert and oriented and self-toilet on 5/17/13. The alert and oriented residents were educated regarding notifying staff when they have bowel movements. The staff	5/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 5/22/13

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.

original signature 5/20/13 nh



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F 309	Continued From page 1 April 2012 revealed an order for a Dulcolax 10 milligram (mg) suppository to be given every three days as needed if the resident had not had a bowel movement. Review of the Medication Administration Records for the month of April 2012 revealed Resident #36 had not recieved the suppository during the month of April 2012. An interview was conducted on 05/02/13 at 12:16 PM with Nurse #1 who worked with Resident #36. Nurse #1 stated if Resident #36 had something ordered she should have recieved it if she had not had a bowel movement in three days. She stated every morning nurses are given a list with residents names who had not had bowel movements in three days. She did not give an explanation as to why Resident #36 did not recieve the suppository that had been ordered if she had no bowel movement in three days. On 05/02/13 at 1:56 PM the Director of Nursing (DON) was interviewed. The DON stated Resident #36 was given prune juice on 04/10/13 and she had a bowel movement. She further stated Resident #36 should have been given the Dulcolax suppository on 04/05/13 when she had not had a bowel movement for three days.	F 309	where interviewed in regards to non-alert and oriented residents and reporting bowel movements. If the resident is not able to report a bowel movement, interventions will be implemented per physician orders if appropriate. If the resident does not have orders, orders will be obtained. The licensed nurses were in-serviced beginning on 5/2/13 regarding the bowel alerts, appropriate intervention and follow-up, and returning the completed bowel alerts to the Director of Nursing. The nursing assistants were in-serviced on 5/2/13 regarding the importance of documenting elimination. The bowel alerts will be run daily by the Director of Nursing or designee and be distributed to the charge nurses for follow-up. Once follow-up has been completed by the charge nurse, the bowel alert sheets will be turned back in to the Director of Nursing for review. The Director of Nursing or designee will track and follow up daily to ensure the bowel protocol is followed, and interventions are continued, the physician is notified as necessary until the resident has a bowel movement.	
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.	F 312	The DON will follow up with the licensed nurses that fail to follow up appropriately and the nursing assistants that fail to document elimination as necessary.	

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F 312	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, family interviews, staff interviews, and medical record review, the facility failed to provide oral care for 1 of 1 residents (Resident #33) requiring extensive or total assistance for activities of daily living. The findings are: Resident #33 was admitted to the facility on 06/07/12. The comprehensive Minimum Data Set (MDS) dated 03/19/13, indicated the resident was severely cognitively impaired and required extensive assistance for personal hygiene. The MDS did not indicate the resident resisted care. During an interview on 04/29/13 at 1:00 PM, family member of Resident #33 indicated that Resident #33's dentures were frequently dirty and Resident #33 always kept her dentures very clean when she was able to take care of them herself or when family assisted her to take care of them. According to Dental Record from Periodic Oral Exam conducted on 03/19/13, the dentist recommended the following: "Remove Denture at night and Clean" ("Clean" is underlined several times). Under the recommendations was handwritten "Clean dentures!" During an interview on 05/01/13 at 11:15 AM, the MDS Coordinator revealed that care cards called "Nurse Aide's Information Sheets" had been developed for each resident for nursing assistants to use as a guide to indicate what care was needed for each resident for each ADL area.	F 312	The Bowel Alert review will be completed by the Director of Nursing or designee on a daily basis for three (3) months to ensure that all residents are having regular bowel movements, the nurses are intervening appropriately, and the nursing assistants are documenting elimination appropriately. The results of those daily audits will be forwarded to the Quality Assurance Committee for review and additional daily monitoring will be determined if necessary. All corrective action will be completed on or before 5/24/2013. F312 The dentures for resident #33 were cleaned and the care plan and care card were updated on 5/2/13. NA #2 was in-serviced by the Director of Nursing on 5/2/13 regarding policy and importance of providing oral/denture care, documenting refusals and utilizing the care cards for information as a guideline for providing care. Oral/denture care is being provided per policy for resident #33. An audit was completed by the Administrative nursing staff on 5/4/213 to determine any resident that needs assistance Oral Care and any resident that wears dentures. The care plans and	5/24/13

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F 312	Continued From page 3	F 312		

F 312 — Summary statement of deficiencies (continued):

The MDS Coordinator also reported that the data system used by nursing assistants had grooming grouped together, so if grooming was checked on a given day, that meant all the grooming skills had been completed that day, including oral care, hair care and nail care. The MDS Coordinator said nursing assistants could document when a resident refused care.

During an interview on 05/01/13 at 11:45 AM, Nursing Assistant (NA) #1 stated that at least since January of 2013, she had taken Resident #33's denture out, cleaned it, and put it back into her mouth in the morning, evening, after each meal, and as needed, each time she was assigned to work with Resident #33. NA #1 stated Resident #33 was totally dependent on caregivers for oral care and did not resist care at all.

During an interview on 05/02/13 at 3:10 PM, Nursing Assistant (NA) #2 stated Resident #33 did not have dentures. NA#2 said she worked with Resident #33 about three days each week and when she worked with Resident #33, she brushed her teeth, gave her mouth wash and performed basic dental care after she ate and after she received a shower. When asked how she knew what type of oral care Resident #33 needed, NA #2 reported she reviewed the care plan and didn't use the care cards.

During an observation of NA #2 providing oral care for Resident #33 on 5/02/13 at 3:20 PM, NA#2 was observed approaching Resident #33 with a toothbrush and toothpaste. When Resident #33 opened her mouth, NA #2 told Resident #33 to wait while she got equipment to

F 312 — Provider's plan of correction:

care cards were reviewed and updated to reflect the need for assistance and whether a resident had dentures or their own teeth. The nursing staff was in-serviced on 5/16/2013 regarding policy and importance of providing oral/denture care, documenting refusals and utilizing the care cards for information as a guideline for providing care.

The DON or designee will complete random oral/denture care audits of at least three residents daily for a period of three months to endure oral/denture care is being provided per policy. The DON will follow up with any nursing staff failing to provide oral care or document refusals as necessary. The results of those daily audits will be forwarded to the Quality Assurance Committee for review and additional daily monitoring will be determined if necessary.

All corrective action will be completed on or before 5/24/2013.

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F 312	Continued From page 4 clean her dentures. When asked why NA #2 had said earlier that Resident #33 had not had dentures, NA #2 stated that she had been confused because most of the time Resident #33 would not let you take out her dentures. NA #2 was observed getting Resident #33's denture cup from her bedside. NA #2 reported the denture cup appeared to be filled with lotion and she went to the nurse's station to get a clean denture cup. When NA #2 returned with a clean denture cup, she washed her hands, put on gloves, and removed Resident #33's upper denture and examined it. The upper denture was coated with food particles and brown solid debris on the top and the bottom. NA #2 reported that the denture should have been cleaned after lunch that day by the nursing assistant assigned to her during first shift. During an interview on 05/02/13 at 3:35 PM, Nurse #1 revealed her expectation of oral care for Resident #33 was that NAs would clean her denture and mouth in the morning, evening, and after meals. When asked what Nurse #1 would expect Resident #33's denture to look like currently, Nurse #1 reported they should be clean with no food or debris on either top or bottom of the denture. When asked what happened when Resident #33 refuseed oral care, Nurse #1 stated the NA must report that to the nurse. Nurse #1 reported she could not remember it ever being reported to her that Resident #33 had refused oral care. Nurse #1 looked up current data for Resident #33 for ADLs and reported that it had been documented that grooming had been provided that day with no refusals. During an interview on 05/02/13 at 3:50 PM, the	F 312		

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F 312	Continued From page 5 Director of Nursing (DON) revealed her expectation regarding oral care for residents that it would be provided twice daily and as needed. The DON reported she would expect at that time, a resident's dentures would not be coated with food. When asked about resident refusals, the DON reported that resident refusals of ADL care was documented on the monthly summaries. During a follow up interview on 05/02/13 at 3:55 PM, the DON reported no refusals of care had been reported by NAs working with Resident #33. According to Resident #33's Care Plan, the following was recorded as a Problem/Need: Alteration in ADL function due to unsteady gait and weakness. (Handwritten here: "She is dependent upon staff for bed mobility, transfers, toileting, eating, bathing, and grooming"). According to Resident #33's Care Card/Nurse Aide's Information Sheet, the following was recorded as needs for mouth care: "No Teeth" and "Total Care" (the box for dentures was NOT checked). According to Beystone Health and Rehab's Policy and Procedure for Dental Care, the following was written: "5. The Nursing Assistant will a. Assist the resident with dental care during a.m. and p.m. care, after meals, and as needed. b. Monitor for loose, missing, decayed, or broken teeth and poorly fitting or broken dentures. c. Monitor for any oral problems and notify nurse."	F 312		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=E	Continued From page 6 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean shelving used to store food items in the walk in refrigerator, maintain an environment in the kitchen to prevent pests from accessing the kitchen and remove a dented can stored ready for use in dry storage. The findings are: 1. During the initial tour of the facility kitchen on 04/29/13 at approximately 10:10 AM three, four tiered open shelving units in the walk in refrigerator were noted to have a significant accumulation of dust and sticky debris covering the surface area. The dirty matter was easily removed when wiped with a paper towel. Food was stored on all the shelving units. On 05/02/13 at 3:20 PM the shelving was noted in the same condition. The Food Service Director (FSD) was present at the time of the observation and noted the accumulation of dust and debris on the surface area of the shelving. The FSD stated the shelving is usually cleaned by aides on a weekly	F 371	F 371 1) The walk-in refrigerator shelves were emptied and removed outside for a thorough cleaning on 5/2/13. Responsible person – Food Service Director. Completed 5/2/13. The morning and evening dietary aide schedule have been adjusted to include a specific assignment of scrubbing and sanitizing the walk in refrigerator shelves on a weekly basis. Responsible persons – dietary aides and Food Service Director. Effective 5/13/13 with not ending duration. The walk in refrigerator shelves will be removed outside for a thorough cleaning by the 7th day of each month. Responsible person – Dietary Aides and Food Service Director. Effective 5/24/13 and ongoing, Sanitation Audit to monitor the walk in refrigerator shelving will be completed no less than 2 x's weekly by the Food Service Director or designee in her absence. Registered Dietitian will review sanitation audits during routine visits. 2) The 1"x 1" hole in the interior bottom seam section in the walk in refrigerator and the ¼" x ¼" hole in the top seam of the walk in refrigerator were repaired on 5/2/13. Responsible person – Maintenance Supervisor. Completed 5/2/13. Maintenance	5/24/13

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F 371	Continued From page 7 basis. The FSD had no explanation why the shelving had a significant accumulation of dust and debris. 2. During the initial tour of the facility kitchen on 04/29/13 at 10:10 AM a 1" X 1" hole was noted on the interior bottom seam section in the walk in refrigerator and an approximate 1/4" X 1/4" hole was noted on the interior top seam. From inside the walk in refrigerator outside daylight was visible through these holes. On 05/02/13 at 3:20 PM these holes remained in the walk in refrigerator. The Food Service Director (FSD) was present at the time of the observation and reported she was not aware of the holes in the walls in the walk in refrigerator. The FSD stated it was a concern and should have been reported to the maintenance director for repair. On 05/02/13 at 4:00 PM the maintenance director reported he was not aware of the holes in the stainless steel in the walk in refrigerator. The maintenance director stated the holes should have been repaired to prevent unwanted pests from entering into the walk in refrigerator through the holes. 3. On 05/01/13 from 10:20 AM-12:20 PM observations were made of the exit door located in the kitchen. The interior door was open leaving the wooden screen door to provide a barrier between the outside area and the interior kitchen. The wooden screen door did not fully close; exposing an approximate 1" gap at the bottom of the door. On 05/02/13 at 12:00 PM the wooden screen door was observed with the same 1" gap. On 05/02/13 at 3:30 PM the wooden screen door was noted in the same position, with an approximate 1" gap at the bottom of the door. The Food Service Director (FSD) was present at	F 371	supervisor inspected the entire walk in refrigerator for any further holes. None where found or needed repair. Inspection done on 5/2/13. A work order book has been placed in the Food Service Department and the Maintenance Supervisor will check daily for any new service requests. Food Service staff in-serviced on work order process on 5/19/13 by the Food Service Director and Registered Dietitian. Any new work orders for 3 months will be forwarded to the Quality Assurance Committee for review and additional daily monitoring will be determined if necessary. 3) The wooden screen door exposing an approximate 1" gap at the bottom of the door leading to the exterior of the kitchen was removed 5/3/13. The interior door has been equipped with an automatic closure device and skid plates to not have any further exposures to the outside. Responsible person – Maintenance Supervisor. Completed 5/3/13. A work order book has been placed in the Food Service Department and the Maintenance Supervisor will check daily for any new service requests. Food Service staff in-serviced on work order process on 5/19/13 by the Food Service Director and Registered Dietitian. Any new work orders for 3 months will be forwarded to the Quality Assurance Committee for review and additional daily monitoring will be determined if necessary.	

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

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F 371	Continued From page 8 the time of the observation and reported she did not realize the wooden screen door did not fully close shut. The FSD stated the concern should have been reported to the maintenance director for repair. On 05/02/13 at 4:00 PM the maintenance director reported he was not aware the wooden screen door in the kitchen did not fully close. The maintenance director stated the door could be repaired to prevent unwanted pests from entering the kitchen area. 4. On 05/02 at 3:20 PM a 50 ounce can of cream of potato soup was observed stored ready for use on shelving in dry storage. The top lid of the can of soup had a large 1 1/2" X 2" dent involving the rim. The Food Service Director (FSD) stated dented cans were supposed to be removed from storage and placed in an area designated for can return. The FSD could not explain why the can of cream of potato soup had not been removed when the large rim dent had been noted.	F 371	4) The dented 50 ounce can of potato soup noted in the dry storage area was disposed of 5/2/13. Responsible person – Food Service Director. Food Service Director has designated a place for storage of dented cans and has posted a sign in the dry storage area. Signage was posted 5/13/13. Sanitation audits to monitor proper storage of dented cans will be completed no less than 2 x's weekly for 3 months by the Food Service Director or designee in her absence. Registered Dietitian will review sanitation audits during routine visits. In-service of all dietary staff regarding the rationale and procedure for assuring food storage areas are kept clean, sanitary, free from dented can, risk of food poisoning/contamination was completed on 5/19/13 by Food Service Director and Registered Dietitian. Review of Sanitation audit forms and dietitian reports will be submitted to the Quality Assurance Committee to monitor compliance and address concerns and make recommendations to determine if further monitoring is necessary. All corrective action will be completed on or before 5/24/2013.	