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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING ______ B. WING ______	C 06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HOME HEALTH AND REHAB	200 HERITAGE DR HENDERSONVILLE, NC 28739

(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 observation, record review, and resident and staff interviews, the facility failed to document accurate skin assessments and schedule an ordered specialty referral for 1 of 5 residents (Resident #5). Findings included: Resident #5 was admitted to the facility on 10/04/12 with diagnoses including osteoarthritis and dementia. The most recent quarterly Minimum Data Set (MDS) dated 04/16/13 indicated the resident's cognition was moderately impaired. The MDS described Resident #5 was usually understood and could usually understand others. Resident #5 required extensive one to two person assistance with dressing, toileting and personal hygiene and total one person assistance with bathing. The Resident was coded as at risk for developing a pressure ulcer and without other skin problems. Her care plan included the potential for skin breakdown and having a self care deficit. Review of Resident #5's medical record revealed a Nurse Practitioner's (NP) progress note dated 01/24/13 documenting a skin lesion on the	F 309	**The submission of the Plan of Correction does not constitute agreement on the part of Mountain Home Health and Rehabilitation Center that the deficiency cited with the report represent deficient practices on the part of Mountain Home Health and Rehabilitation Center. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.** **Tag: 309---Provide Care/Services for Highest Well Being** **Corrective action for identified residents:** Resident #5 was seen by the dermatologist on June 11, 2013. **How other residents with the potential for deficient practice identified:** All residents in the facility will receive a head to toe skin assessment to identify areas requiring medical treatment by June 30, 2013. All abnormal findings will be reported to the Nurse Practitioner for follow-up.	6-30-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/27/13

DHSR - L & C Black Mountain NRO Received JUL 01 2013 by: MMH

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 309	Continued From page 1 Resident's left upper arm. The note documented measurement of 1 centimeter with a description of a pink and flat lesion without central scabbing, also having a smooth border. The note documented the plan to refer the Resident to a dermatologist. A review of NP orders dated 01/24/13 revealed a referral to dermatology for a left upper arm skin lesion. Review of the medical record did not reveal any dermatology reports. Review of weekly skin assessment forms revealed documentation of no new skin issues for the period of 01/02/13 through 06/05/13. Review of nursing notes dated 05/21/13 revealed documentation of a dry scab about the size of a dime on Resident #5's left upper arm, with notification of the NP for a dermatology referral. Review of medical orders dated 05/21/13 revealed a dermatology referral for a skin lesion on the Resident's left upper arm. Review of van transportation log sheets for the period of January through May 2013 revealed one entry dated 04/09/13 for Resident #5 to attend a group activity out of the facility. An interview with Nurse Aide (NA) #1 on 06/05/13 at 3:00 PM revealed she was familiar with Resident #5 and acknowledged nothing unusual regarding the resident's care. NA #1 stated if there was something wrong the resident would let you know and that the resident was pretty much on her own. An interview with the NP on 06/06/13 at 2:00 PM revealed she was aware of Resident #5's history of skin lesions. The NP stated the facility van transporter received order copies for all referrals	F 309	All Licensed staff will be in-serviced on proper method for completing a head to toe assessment and proper follow-up by June 30, 2013. All resident charts will be audited from January 1, 2013 to present to ensure all referral orders have been noted and appointments have been made and communicated to Transportation Aide. This audit will be completed by June 30, 2013. All Licensed staff will be in-serviced on processing orders for appointments and the proper way to communicate them to the Transportation aide by June 30, 2013 A copy of all orders for referrals outside facility will be placed in Director of Nursing box at Nursing Station for follow-up by Director of Nursing or designee at the time the order is taken.	6-30-13 6-30-13 6-30-13

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F 309	Continued From page 2 to make appointments and schedule transportation. The NP stated she would expect nurses to report such a skin finding. An interview with Resident #5 on 06/06/13 at 3:32 PM revealed she acknowledged the presence of a skin condition on her upper left arm. The Resident stated a scab would fall off a lesion after growing larger, without bleeding but the area would turn red with new scab formation. Resident #5 stated the skin lesion would itch and sting, especially in the summer. She stated at the time of the interview that the lesion stung and would get irritated when clothing rubbed against it. Resident #5 stated she told staff about the skin lesion a couple of times, both nurses and people "in the office." The Resident stated she was told about a month previous the facility would get someone to examine it but this had not yet occurred. Resident #5 stated having similar skin lesion issues in her past requiring evaluation and treatment by a doctor in her hometown. The Resident stated she needed something done to get rid of the skin lesion. An interview with the facility Van Transporter on 06/06/13 at 3:50 PM revealed it was her responsibility to book referral appointments for residents when notified by nursing staff. Based on a review of her appointment book, the Van Transporter stated Resident #5 was scheduled to see a dermatologist at a future appointment on 06/11/13. She could not remember the exact date when she made the appointment although it was recent. Based on her review of her appointment book, the Van Transporter stated she did not have documentation of a dermatology appointment for Resident #5 on or after 01/24/13	F 309	**Systematic changes made to ensure deficient practice does not reoccur:** An audit of all skin assessment sheets will be completed weekly for 4 weeks, monthly for 6 months and then quarterly for 6 months by the Director of Nursing or Designee for one year. Any issues will be reported to the Quality Assurance Committee by the Director of Nursing monthly. During daily acute charting review, the nurse will place a copy of orders for outside appointments in the Director of Nursing box at nurse's station. Director of Nursing or Designee will match up the copy of orders placed in her box by ordering nurse. The Director of Nursing or Designee will verify the appointment occurred. Any discrepancies will be reported to the Quality Assurance Committee monthly. **Facility monitoring process:** Director of Nursing or Designee will monitor monthly for six months and then quarterly for six months to insure continued compliance and report to the Quality Assurance.	

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F 309	Continued From page 3 through to the most recent and pending appointment of 06/11/13. An observation on 06/06/13 at 4:00 PM revealed Nurse #1 assessed Resident #5's left upper arm. After Nurse #1 obtained the resident's permission and rolled back the sleeve of her shirt, a dry and flaky circular scabbed area, approximately 1 centimeter in diameter, was observed on the inner aspect of Resident #5's left upper arm. A thin ring of reddened skin surrounded the scabbed area. The skin lesion was observed to be raised approximately 0.5 centimeters above the surround skin. An interview on 06/06/13 at 4:00 PM with Nurse #1 revealed she was not aware of Resident #5's skin condition on her left upper arm and she did not recall it ever being reported to her by other nursing staff. Nurse #1 stated the skin condition appeared as a circular scabbed area with slight surrounding redness. She stated she would not consider this a normal skin assessment on a head to toe skin check but would document it as an abnormal finding. Nurse #1 stated she recalled a referral for Resident #5 to see a dermatologist but she could not provide more information. An interview on 06/06/13 at 5:30 PM with Nurse #1 revealed when referrals to specialists were ordered, nurses were expected to make a copy of the order and give it to the facility Van Transporter to book the appointment. She stated when the appointment time and date were obtained, this information would be written on a desk calendar at the nurse's station so nurses would know to have the resident ready for	F 309		

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F 309	Continued From page 4 transport to their appointment. Nurse #1 stated her review of the desk calendar revealed no calendar months past May 2013. Nurse #1 stated referrals were also to be noted on the the 24 hour nurse communication form. An interview on 06/06/13 at 5:45 PM with the Director of Nursing (DON) revealed most nurses coordinated with NAs to complete ordered head to toe skin checks on shower days. The DON stated NAs were expected to alert nurses of any skin concerns, old or new. She stated it was the nurse's responsibility to do head to toe skin checks but NAs also documented their findings on shower sheets as a temporary communication tool, which were not archived. The DON stated the Assistant Director of Nursing reviewed the shower sheets for significant findings to investigate. She stated if the nurse completed a skin assessment and documented it on the weekly skin assessment form, they were taking responsibility to communicate the findings to providers and other staff. The DON stated head to toe skin checks were basically to assess for skin tears or pressure areas but skin findings of all types should be documented on the weekly skin assessment form.	F 309		