| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345315 | A. BUILDING _____ B. WING _____ | C 04/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HIGHLAND ACRES NURSING AND REHABILITATION CENTER | 1170 LINKHAW ROAD LUMBERTON, NC 28358 |

| (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 |
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| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews the facility failed to trim fingernails for 1 of 1 residents reviewed for hand contracture. (Resident #11) The findings included:<br>Resident #11 was admitted to the facility on 5/5/10 and re-admitted to the facility on 3/16/15. The resident had diagnoses that included Cerebrovascular Accident (Stroke) with Left Hemiplegia (paralysis).<br>The most recent MDS (Quarterly) dated 2/23/15 revealed the resident required total assistance with personal hygiene and had impairment of the upper extremities on both sides. The MDS revealed the resident received hospice care.<br>The resident ' s Care Plan last reviewed on 2/25/15 revealed the resident was total care for personal hygiene and grooming.<br>Review of the Nail Care Book revealed Resident #11 ' s nails were last trimmed on 4/3/15.<br>On 4/15/15 at 3:25PM Resident #11 was observed with the left thumb and index finger extended but the left middle, ring and little fingers were curled into the palm of the hand. The resident ' s fingernails extended approximately 1/4 " beyond the end of the thumb and index finger.<br>On 4/16/15 at 9:58AM, Occupational Therapist (OT) #1 was observed to evaluate the resident ' s | F 312 | Resident #11 had his fingernails cut by the Director of Nursing on 4-16-15.<br>A 100 % audit of all resident□s fingernails was completed by the supply manager on 4-18-15. All residents with nail concerns were addressed upon identification.<br>A 100 % in □service was completed by the Director of Nursing, the Assistant Director of Nursing, and the Staff Facilitator on 4-17-15 with the nurses and the certified nursing assistants on ADL<br>care, to include fingernail care. The Hospice Nurse in □ serviced the hospice aides<br>and the hospice nurses on ADL care, to include fingernail care on 4-17-15. All new hires will be in-serviced by the staff facilitator during orientation on ADL care to include fingernail care. Administrative staff will observe fingernails to ensure care has been completed 5 times a week for 8 weeks utilizing a QI tool and turn them into the Administrator and / the DON. The Administrator and / or the DON will review the QI tool daily for 8 weeks. Any identified concerns with fingernails | 4/22/15 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/05/2015

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| F 312 | Continued From page 1<br>left hand contracture. The OT was able to partially open the resident ' s contracted fingers. The palm of the resident ' s hand was observed to have indentions in the palm and the OT stated he saw the indentions from the resident ' s fingernails. The resident ' s skin in the palm of the hand was observed to be intact. The resident ' s fingernails extended approximately 1/4 " beyond the end of the contracted fingers.<br>Nurse #1 stated in an interview on 4/16/15 at 10:11AM the administrative staff made rounds every morning and looked at the residents and let the NA know if a resident ' s nails needed to be trimmed. The Nurse stated the NAs were supposed to look at resident ' s nails during AM (morning) care and trim the nails if needed. The Nurse stated the hospice aide had been doing AM care during the week.<br>On 4/16/15 at 10:34AM the Director of Nursing (DON) stated in an interview the NAs (Nursing Assistants) provided care every day and ultimately trimmed resident ' s fingernails. The DON stated the transportation aide was supposed to spot check one hall a week to look at resident ' s nails to see if the nails needed to be trimmed and if so, she would do it. The DON stated the hospice aide did not trim nails.<br>The DON stated in an interview on 4/16/15 at 11:18AM that Resident #11 ' s nails needed to be trimmed and she had a staff member go down and trim the resident ' s fingernails. The DON stated an employee from payroll was assigned to the hall where the resident resided and last made rounds on the hall on 4/7/15. The DON stated she could not say why the resident ' s nails were not addressed before now.<br>On 4/16/15 at 12:15PM, the Payroll Employee assigned to the hall on which Resident #11 resided stated in an interview that she tried to | F 312 | will be listed on the fingernail log by the Administrator and / or the DON. The Administrator and / or the DON will review the log daily at the morning meeting and initiate appropriate interventions for any identified areas of concern. The transportation manager will clean and cut residents nails on one hall a week and document that on a nail log as a part of her job duties. The Quality Improvement will review the QI tool weekly for 4 weeks, monthly for 3 months for areas of concern. The Executive Committee will review the recommendations of the weekly QI Committee monthly for 3 months for the frequency and need of continued monitoring. | |

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| F 312 | Continued From page 2<br>make rounds every day but was busy and not able to get down the halls every day. The Payroll Employee stated she last did rounds on that hall on 4/7/15 and the nail care book showed the resident ' s nails were last cut on 4/3/15. The Payroll Employee stated if a resident ' s nails needed to be cut she would notify the nurse. The Payroll Employee stated she was supposed to do 2 rounds per day and on the second round if she saw the resident ' s nails had not been cut she would go back to the nurse who would have to get with the NA to make sure the nails got cut. The Administrator stated in an interview on 4/16/15 at 12:51PM administrative rounds were typically done daily to check the resident ' s room and personal care including fingernails. The Administrator stated each room was not checked every day. The Administrator stated the nurse and the NA should have picked up on the long fingernails. | F 312 | | |
| F 317 SS=G | 483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews the facility failed to provide services to prevent the development of a hand contracture for 1 of 1 resident reviewed for contractures | F 317 | Resident number 11 was assessed for Contractures by the Assistant Director of Nursing on 4-16-15. A referral was made to therapy for resident #11 by the Director | 4/22/15 |

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| F 317 | Continued From page 3<br>(Resident #11). The findings included:<br>Resident #11 was admitted to the facility on 5/5/10 and re-admitted on 3/16/15. The resident had a diagnosis of Cerebrovascular Accident (Stroke) with Left Hemiplegia (paralysis).<br>The most recent MDS (Quarterly) dated 2/23/15 revealed the resident had short and long term memory loss but was able to make decisions. The MDS revealed the resident required total assistance for all activities of daily living except for eating and had impairment of the upper extremities on both sides. The MDS revealed the resident received hospice care.<br>The resident ' s Care Plan last reviewed on 2/25/15 revealed no information regarding contractures or range of motion for the resident ' s left hand. The resident ' s Care Guide revealed no information related to contractures or range of motion.<br>A Nursing Admission & Re Entry form dated 3/16/15 and electronically signed by Nurse #1 under general comments read: " Full ROM (range of motion) in extremities. "<br>On 4/15/15 at 3:25PM, Resident #11 was observed to have the left index finger and thumb extended and was observed to use the fingers to adjust the bed covers. The left middle, ring and little fingers were observed to be curled inward against the palm of the hand. The resident was observed to use the right hand to try to open the fingers on the left hand but was not able to do so. The resident stated his hand had been like this for about 3 weeks.<br>Review of the progress notes for Resident #11 from 3/16/15 to 4/15/15 revealed no documentation of a problem with the resident ' s left hand.<br>On 4/15/15 at 3:27PM an interview was conducted with the NA (nursing assistant) | F 317 | of Nursing on 4-16-15. Resident # 11 stated<br>he wanted therapy. Hospice was called and<br>Resident number 11 was discontinued from<br>hospice services on 4-17-15. Resident #11<br>was referred to and placed on therapy on 4-16-15<br>A 100 % audit for contractures was completed on all<br>residents on 4-16-15 by the hall nurses using<br>a skin assessment tool and turned into the Director of Nursing. From the 100% audit on<br>4-17-15 any identified residents at risk were referred to therapy. All new admissions will be assessed by the wound nurse using a skin assessment tool within 48 hours of their admission and will be turned into the Director of Nursing daily .<br>The Director of Nursing, The Assistant Director of Nursing, and the Staff Facilitator completed a 100% in □ service on 4-22-15 on contractures, range of motion, communication of what is found during the assessment to ensure implementation of interventions, and on ensuring that all interventions are implemented with all Nurses which included hospice employee's. The staff facilitator completed a 100 % in □ service with all c.n.a.□s on range of motion and on communication of contractures to their hall nurse. Hospice completed an in □service on 4-17-15 by the RN Hospice Nurse with the hospice aides of the facility | |

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| F 317 | Continued From page 4<br>assigned to the resident on the 3PM-11PM shift. NA #1 stated when she tried to open the resident ' s left hand the resident would say that it hurt. The NA stated the resident did not receive range of motion to the hand and did not have a splint.<br>The Director of Nursing (DON) stated in an interview on 4/16/15 at 9:47AM that Resident #11 did not have a hand splint or a hand roll. The DON stated the resident had been on hospice since 8/29/13 but the resident ' s condition had improved and there had been a discussion about discontinuing hospice. The DON stated this was a new contracture and hospice would be discontinued and a therapy referral would being made regarding the hand contracture.<br>On 4/16/15 at 9:58AM, Resident #11 was observed lying in bed with 1/4 side rails up on the bed. The Occupational Therapist (OT) was observed to evaluate the resident ' s left hand contracture. The OT stated the resident ' s left hand was contracted and was observed to partially open the left middle, ring and little fingers. The resident was observed to use the left thumb and index finger to hold onto the side rail on the bed and assist the OT to turn over in bed. The resident told the therapist his hand had been like this for about 5 weeks. The Therapist asked the resident if he wanted to work with therapy to improve the mobility in the hand and the Resident stated: " Yes. " The OT stated he would recommend a double hand roll and would need to come back and measure the resident for a splint.<br>An interview was conducted with the hospice aide that provided AM care for the resident regularly on 4/16/15 at 10:25AM. The Hospice Aide stated she had been working with Resident #11 for a long time. The Hospice Aide stated she noted the resident ' s left hand contracting but could not say how long but was a matter of weeks and not | F 317 | on range of motion and on communicating on<br>contractures to their hall nurse. All new c.n.a.'s will be in-serviced on range of motion and on communication of contractures to their hall nurse during the orientation process. All new nurses will be in-serviced on contractures, range of motion, communication of what is found during the assessment to ensure implementation of interventions, and on ensuring that all interventions are implemented during the orientation process. The MDS nurse will assess all residents during the resident assessment period for new contractures using a QI tool and will turn it into the Director<br>of Nursing or the Administrator daily for 4 weeks, weekly for 4 weeks, and monthly for 3 months. MDS Nurse or the Director of Nursing<br>will make a referral to therapy for any area of<br>concerns. The hall Nurses will assess residents<br>weekly and ongoing for contractures using a skin assessment tool. The Assessment for contractures will be a weekly duty for the hall nurses and will be monitored by the Administrator and / or the DON daily. All identified concerns will be referred to therapy. The assessment tool will be turned in daily for 4 Weeks to The Director of Nursing or the<br>Administrator, weekly for 8 weeks,and monthly<br>for 3 months. The Director of Nursing and / | |

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| F 317 | Continued From page 5<br>months. The Hospice Aide stated she spent about an hour with the resident in the morning during the week to give the resident a bath. The Hospice Aide stated she had not had a conversation with any of the staff regarding the resident ' s hand contracture.<br>The DON stated in an interview on 4/16/15 at 10:34AM the NAs provide care every day and if a problem with range of motion was observed, the NAs were to report to the nurse and the nurse would make a referral to therapy and notify the physician.<br>NA #2 stated in an interview on 4/16/15 at 10:44AM that she was frequently assigned to Resident #11. The NA stated after the resident came back from the hospital she saw the fingers of the left hand were bent and told Nurse #2 and she said OK. The NA stated she had not been assigned to the resident all week but when she did work with the resident she did range of motion with the left fingers.<br>On 4/16/15 at 11:02AM Nurse #1 stated in an interview when the resident was re-admitted on 3/16/15 she saw the resident ' s left fingers curled a little bit but the resident was still able to pick up items and use the left hand. The Nurse stated she did not see the hand was contracted until she was asked about the resident ' s contracture on 4/16/15. The Nurse stated on 4/16/15 she looked at the resident ' s hand and asked him if he wanted a splint and the resident stated: " No. " The Nurse stated she looked around the room and did not see a splint. The Nurse stated she did not tell anyone about the contracture because the resident was on hospice and she knew he was not receiving any kind of therapy. The Nurse stated the NAs had not said anything to her regarding the resident ' s hand.<br>Nurse #2 stated in an interview on 4/16/15 at | F 317 | or the Administrator will review the QI tools<br>at the weekly QI meeting for 8 weeks, and monthly for 3 months for areas of concern. All identified areas of concern will be addressed as they are identified.<br>The Executive Quality Improvement Committee will review the results of the QI Meeting minutes for the continued need and frequency of monitoring monthly for 4 months. | |

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| F 317 | Continued From page 6<br>11:05AM that no one had said anything to her about a problem with the resident ' s left hand.<br>The OT stated in an interview on 4/16/15 at 11:13AM that the resident had not been referred to therapy since being re-admitted to the facility on 3/16/15. The OT provided a copy of the evaluation done on 4/16/15. The Occupational Therapy Plan of Care dated 4/16/15 revealed increased flexor tone in all MPs (metacarpophalangeal) on the left hand as a result of left extremity CVA for the past 3-5 weeks per patient report. Pain noted with passive range of motion. Under Therapy Necessity read: " Skilled OT is necessary to normalize muscle tone in order to maximize UE (upper extremity) function and allow the patient to perform bed mobility with the least amount of assistance and prevent contracture. " The treatment diagnosis was Joint Contracture-Multiple Joints.<br>The DON stated in an interview on 4/16/15 at 11:18AM when the resident told Nurse #1 he did not want a splint, the nurse should have documented this and not done anything further. The DON stated the resident ' s family always said to do what the resident wanted to do. The DON stated anyone could put a hand rolled washcloth in the resident ' s hand and tell the nurse who would communicate this to the MDS Nurse who would revise the care plan and the care guide.<br>The Administrator stated in an interview on 4/16/15 at 12:57PM that Nurse #1 should have made a referral to therapy to see what could be done for the resident ' s contracture even if the resident was on hospice. | F 317 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION | F 318 | | 4/22/15 |

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| F 318 | Continued From page 7<br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews the facility failed to provide services to prevent a further decline in range of motion for 1 of 1 residents reviewed for contractures (Resident #11). The findings included:<br>Resident #11 was admitted to the facility on 5/5/10 and re-admitted on 3/16/15. The resident had a diagnosis of Cerebrovascular Accident (Stroke) with Left Hemiplegia (Paralysis).<br>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 2/23/15 revealed the resident had some short and long term memory loss and was able to make some decisions. The MDS revealed the resident required total assistance for all activities of daily living except for eating and had impairment in range of motion of the upper extremities on both sides. The MDS revealed the resident received hospice services.<br>The resident ' s Care Plan last reviewed on 2/25/15 revealed no information regarding contractures or impaired range of motion for the resident ' s left hand. The resident ' s care guide revealed no information regarding contractures or impairment in range of motion.<br>A Nursing Admission & (and) Re Entry form dated 3/16/15, under General Comments read: " Full ROM (range of motion) in extremities. " The form | F 318 | Resident number 11 was assessed for Contractures by the Assistant Director of Nursing on 4-16-15. A referral was made to therapy for resident #11 by the Director of Nursing on 4-16-15. Resident # 11 stated<br>he wanted therapy. Hospice was called and<br>Resident number 11 was discontinued from<br>hospice services on 4-17-15. Resident #11 was<br>referred to and placed on therapy on 4-16-15.<br>A 100 % audit for contractures was completed on<br>4-16-15 by the hall nurses on all residents using<br>a skin assessment tool and turned into the Director of Nursing. From the 100% audit on<br>4-16-15 any identified resident was referred to therapy on 4-17-15. All new admissions will be assessed by the wound nurse using a skin assessment tool within 48 hours of their admission and will be turned into the Director of Nursing daily.<br>The Director of Nursing,The Assistant | |

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| F 318 | Continued From page 8<br>was electronically signed by Nurse #1.<br>Review of the progress notes from 3/16/15 to 4/15/15 revealed no documentation regarding limited range of motion or of a contracture of the resident ' s left hand.<br>On 4/15/15 at 3:25PM Resident #11 was observed in bed. The resident ' s left index finger and thumb were observed to be extended and the resident using the finger and thumb to adjust the bed covers. The left middle, ring and little fingers were observed to be curved into the palm of the hand. There was not a hand roll in the resident ' s hand. The resident was not able to straighten the fingers even with the use of the right hand. The resident was observed to have good range of motion of the right hand.<br>On 4/15/15 at 3:27PM an interview was conducted with NA (nursing assistant) #1 who was assigned to the resident on the 3PM-11PM shift. The NA stated when she tried to open the resident ' s hand he would say that it hurt. The NA stated they did not do range of motion to the hand and the resident did not have a splint for the hand.<br>The Director of Nursing (DON) stated in an interview on 4/16/15 at 9:47AM this was a new contracture for the resident and a therapy referral would be requested. The DON stated the resident did not have a hand splint or a hand roll.<br>On 4/16/15 at 9:58AM, Resident #11 was observed lying in bed with 1/4 side rails up on the bed. The Occupational Therapist (OT) was observed to evaluate the resident ' s left hand contracture. The OT stated the resident ' s left hand was contracted and was observed to partially open the left middle, ring and little fingers. The resident was observed to use the left thumb and index finger to hold onto the side rail on the bed and assist the OT to turn over in bed. | F 318 | Director of Nursing, and the Staff Facilitator completed a 100% in □ serviceon 4-22-15 on contractures, range of motion, communication of what is found during the<br>assessment to ensure implementation of interventions,<br>and on ensuring that all interventions are implemented with all Nurses, which included hospice employee's. The staff facilitator completed a 100 % in □ service on 4-22-15 with all c.n.a.□s on range of motion and on communicating on contractures to their hall nurse. Hospice completed an in □service on 4-17-15 by the RN Hospice Nurse with the hospice aides of the facility on range of motion and on communicating on contractures to their hall nurse. The staff facilitator will in-service all new c.n.a.'s on range of motion and on communicating about contractures to their hall nurse during orientation. The staff facilitator will in- service all new nurses on contractures, range of motion, communicating what is found during the assessment to ensure that all interventions are implemented during orientation. The MDS nurse will assess all residents during the resident assessment process for new contractures using a QI tool and will turn it into the Director of Nursing or the Administrator daily for 4 weeks, weekly for 4 weeks, and monthly for 3 months.The MDS Nurse or the Director of Nursing will make a referral to therapy for any area of concern. The hall Nurses will assess residents weekly for contractures using a skin assessment tool. All identified concerns will be | |

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| HIGHLAND ACRES NURSING AND REHABILITATION CENTER | 1170 LINKHAW ROAD LUMBERTON, NC 28358 |

| (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 |
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| F 318 | Continued From page 9<br>The resident told the therapist his hand had been like this for about 5 weeks. The Therapist asked the resident if he wanted to work with therapy to improve the mobility in the hand and the Resident stated: " Yes. " The OT stated he would recommend a double hand roll and would need to come back and measure the resident for a splint.<br>On 4/16/15 at 10:25AM an interview was conducted with the hospice aide that worked with the resident. The Hospice Aide stated she was with the resident for about an hour in the morning during the week to give the resident a bath. The Hospice Aide stated she had noted the resident ' s left hand contracting but did not know when she first saw this but had been weeks and not months. The Hospice Aide stated she had not had a conversation with the staff regarding the worsening hand contracture.<br>On 4/16/15 at 10:34AM the DON stated in an interview the NAs provide care every day and if they observe a problem with range of motion they should tell the hall nurse and the nurse would make a referral to therapy and notify the physician.<br>Nurse #1 stated in an interview on 4/16/15 at 11:02AM she did the re-admission assessment on 3/16/15 when the resident was re-admitted from the hospital. The Nurse stated she noted the resident ' s left hand was curled in a little but the resident was still able to pick up items and use his hand. The Nurse stated she was not aware the resident had a contracture of the left hand until she was asked about the contracture on 4/15/15. The Nurse stated she looked at the resident ' s left hand and asked the resident if he wanted a splint and the resident stated: " No. " The Nurse stated she looked around the room and did not see a splint. The Nurse stated she did not tell anyone else because the resident was on | F 318 | referred to therapy. The assessment tool will be turned into The Director of Nursing or the Administrator daily for 4 weeks, weekly for 4 weeks,and monthly for 3 months. The Director of Nursing and / or the Administrator will review the QI tools at the weekly QI meeting for 8 weeks and monthly for 3 months for areas of concern. All identified areas of concern will be addressed as they are identified. The Executive Quality Improvement Committee will review the results of the QI Meeting minutes for the continued need and frequency of monitoring at the Executive Committee meeting for 4 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345315 | A. BUILDING _____ B. WING _____ | C 04/16/2015 |

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| F 318 | Continued From page 10<br>hospice and he was not getting any kind of therapy.<br>The Occupational Therapist stated in an interview on 4/16/15 at 11:13AM that therapy had not received a referral for Resident #11 since the resident was re-admitted on 3/16/15.<br>The DON stated in an interview on 4/16/15 at 11:18AM that anyone could put a hand rolled washcloth in the resident ' s hand and tell the nurse who would communicate this with the MDS Nurse who would revise the care plan and the care guide.<br>The Administrator stated in an interview on 4/16/15 at 12:57PM that a referral to therapy should have been done to see what could be done for the resident ' s contracture. | F 318 | | |