

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE FOUNTAINS AT THE ALBEMARLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 TRADE STREET TARBORO, NC 27886</b>		
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F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview the facility to serve food to 1 of 12 residents (#39) in the dining room close to the time the other residents were served and failed to provide prompt feeding assistance for a 1 of 11 residents (#13) who could not feed herself. The findings included: 1. The Quarterly Minimum Data Set (MDS) dated 4/12/15 revealed Resident #39 was severely cognitively impaired and required extensive assistance with eating. During a dining observation on 5/18/15 which began at 12:15 PM Resident #39 was seated at the table with 2 other residents. At 12:20 PM NA (Nursing Assistant) #1 and NA #2 were each feeding another resident at the table where Resident #39 was seated. There were 8 other residents seated throughout the dining room and all were eating their lunch meal. Resident #39 did not have any food present. She was observed sitting in her wheel chair at the table just looking around and nodding off to sleep. At 1:02 PM the staff began assisting residents who had finished eating from the dining room. At 1:03 PM Resident #39 was served her food and the ADON (Assistant Director of Nursing) began feeding her. During an interview on 5/20/15 at 11:35 AM the Director of Nursing stated the staffing schedule was adjusted using a corporate computer</p>	F 241	<p>On 5/18/2015 (Day One of the Survey), immediately upon discovery that Resident #39 did not receive prompt feeding assistance, the Assistant Director of Nursing met with the Certified Nursing Assistants to discuss how we failed to serve and assist Resident #39 in a timely manner and to discuss immediate interventions necessary to ensure the deficient practice will not re-occur.</p> <p>First intervention was to ensure Resident #39 and Resident #13 are seated at a dining table where there are sufficient number of dining staff to assist them with their meals promptly upon arrival. Although the Certified Nursing Assistant staffing schedule is adjusted using a corporate computer program based on the census, the needs of the residents requiring assistance will supersede the need to adjust staffing until after meals are completed. No further deficient practice has occurred after the Survey. Completion Date: 5/21/2015</p> <p>On 6/8/2015, the Assistant Director Of Nursing met with a select number of Certified Nursing Assistants to determine</p>	6/12/15	

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

TITLE

(X6) DATE

Electronically Signed

06/12/2015

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 241	<p>Continued From page 1</p> <p>program and based on the census. She stated she was not aware that Resident #39 was not fed until the other residents at her table had finished eating.</p> <p>2. The Quarterly MDS dated 2/22/15 revealed resident #13 was severely cognitively impaired and required supervision encouragement or cueing with eating.</p> <p>During a dining observation on 5/19/15 which began at 12:15 PM there were 11 resident seated in the dining room for the lunch meal. There were 6 staff members present and each staff member was feeding a resident. Resident #13 was seated at a table with one other resident who was able to feed himself. Resident #13 was observed trying to eat peaches from the bowl but she was unable to so she put the bowl to her mouth and drank the liquid from the bowl. She was then observed to pick up her fork. Additional observation revealed she attempted multiple times to put the fork inside a cup which had a lid covering the top of the cup. There was a straw present in the lid of the cup and she tried multiple times to drink from the covered rim of the cup. The resident was not able to use her fork to obtain the food from her plate or drink the fluid from her cup.</p> <p>At 12:27 the Dining Services Manager moved her fruit bowl closer and adjusted the Resident's plate. At 12:33 PM NA #3 asked Resident #13 if she was OK but did not attempt to assist the Resident with eating. At 12:35 PM the staff began assisting residents who had finished eating from the dining room. At 12:44 PM Nurse #1 asked NA #4 to help Resident #13. NA #4 was observed to move a chair to the table and she sat down to assist Resident #4 with the lunch meal by showing her how to place her fork into food items on her plate and by placing her drinking cup straw</p>	F 241	<p>a dinig protocol that will promote care for the residents in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Upon reviewing the dining needs and preferences of each resident, the Assistant Director Of Nursing generated a seating chart to ensure that all residents are served and given assistance at the same time by the Certified Nursing Assistants, Nurses and/or trained servers.</p> <p>On 6/08/2015, the Assistant Director Of Nursing held an in-service with the Certified Nursing Assistants, Nurses and trained servers during 1st and 2nd shift report regarding Watermark Retirement Community policy, Dignified Dining &amp; Table Service (WRC-DS-P010) and seating arrangement. The Certified Nursing Assistants were shown a diagram, representing the layout of our skilled nursing dining room, with the new arrangment of how the residents would needed to be seated to ensure that every resident gets the required assistance. The set up was done so that a certified nursing assistant would be available at a table to assist a resident or two that may require complete assistance and a resident that may need cueing or encouragement. Completion Date: 06/08/2015</p> <p>To follow-up implementation of the dining protocol, on 06/08/2015, 06/09/2015 and 06/10/2015, the Assistant Director Of Nursing observed the dining process, in</p>		

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F 241	Continued From page 2 into the resident's mouth. On 5/20/15 at 9:09 AM NA #4 stated she had fed another resident and had taken that resident to her room. She stated when she returned to the dining room Nurse #1 asked her to help resident #13 so she did. She also stated if the resident could not pick up the food she would assist her. NA #4 stated Resident #13 required assistance with eating 25% of the time. During an interview on 5/20/15 at 11:37 AM the Director of Nursing stated she would expect staff to assist residents with eating if they were not able to feed themselves.	F 241	its entirety, during breakfast, lunch and dinner to ensure each resident in need of assistance is promptly served, assisted and encouraged or cued with eating.  Dining protocol includes that all residents will be seated at dining tables according to their level of assistance with feeding. A staff member (Certified Nursing Assistant, Nurse or trained server) will be assigned to a table per diagram to ensure that all residents at the table are served at the same time and assisted promptly. On a daily basis during breakfast, lunch and dinner(21 meals per week), a licensed practical nurse or Registered Nurse will be assigned by the Director of Nursing or Assistant Director of Nursing to supervise the dining room in order to sustain that the residents, who need assistance with feeding and cueing, will be served and assisted in a timely manner. It is the responsibility of the assigned Licensed Practical Nurse or Registered Nurse to facilitate and assist if necessary with feeding, cueing as well as being the Hostess during the dining experience to ensure the dining process runs smoothly. The Licensed Practical Nurse or Registered Nurse will report any issues or concerns regarding the dining process to the Assistant Director Of Nursing and/or the Director of Nursing.  On an ongoing basis, The Assistant Director Of Nursing or Director of Nursing will make weekly rounds in the dining room (alternating various meals) to monitor for any deficient practice and to		

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F 241	Continued From page 3	F 241	sustain the systemic changes implemented. Findings of the dining room rounds will be shared in monthly QI meetings by the Assistant Director of Nursing and documented in the QI meeting minutes.		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278		6/12/15	

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F 278	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the MDS for diagnoses for 1 of 5 residents reviewed for unnecessary medications (Resident #1).</p> <p>Findings included:</p> <p>Resident #1 was admitted on 12/8/2013 with diagnoses which included persistent mental disorder, depression and Alzheimer's disease.</p> <p>Review of Resident #1 most recent Quarterly MDS (Minimum Data Set) assessment which was dated 4/30/2015 indicated Resident #1 had received Antipsychotic, Antianxiety and Antidepressant medications daily during the look back period (4/24/2015 through 4/30/2015). The MDS assessment also indicated Resident #1 had short term memory problems and continuously present behaviors including inattention and disorganized thinking. No diagnoses for persistent mental disorder, depression or anxiety were included on this assessment.</p> <p>A record review was conducted and indicated Resident #1 had received the following medications during the look back period (4/24/2015 through 4/30/2015): Ativan 0.25mg (milligrams) in the morning Ativan 0.5mg at bedtime for anxiety Ativan 0.5mg every 4 hours as needed for agitation, combativeness or anxiety Trazodone 25mg at bedtime as needed for insomnia Risperidone 0.5mg every morning for depression Risperidone 0.25mg every evening for depression Zolof 25mg every morning for depression</p>	F 278	<p>The Minimuc Data Set (MDS) assessment must accurately reflect the resident's condition. The Registered Nurse must conduct and coordinate a thorough assessment with the appropriate participation from other healthcare professionals. Every health care professional who completes a section of assessment must sign and verify that it is accurate. The Registered Nurse must sign and verify that the Minimum Data Set (MDS) assessment is accurate and completed in a timely manner.</p> <p>During the survey from May 18-20, 2015, it was determined that the requirement had not been met after a review of resident #1's MDS assessment. Resident #1 had a history of anxiety, depression, Alzheimer's disease, and persistent mental disorder. These diagnoses had not been addressed on the quarterly assessment due to not being on the physician order slips or medication administration record.</p> <p>Resident #1 diagnoses were updated in Point Click Care (clinical software) on 6/5/2015. The Medication Administration Record was also updated to reflect the following changes: Ativan to be given for treatment of Anxiety, Trazodone for anti-depressant, Risperidone for treatment of Depressive Psychosis and Zolof 25mg indicated for treatment of Depression. The Medical Director was contacted to ensure these diagnoses for medications meet the</p>		

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F 278	Continued From page 5  The record review also indicated monthly pharmacist medication reviews with gradual dose reduction recommendations. The most recent physician note was dated 4/27/2005 and indicated "the patient has a history of anxiety, psychosis dementia with behavioral disturbance and insomnia currently being addressed without side effects. No psychotic symptoms noted or reported. Recommendations to continue medications as prescribed, the patient is stable at current dose and/or needs more time to see beneficial effects. Dose reduction attempted and/or reduction will cause decompensation of patient."  An interview with the MDS nurse and the MDS nurse consultant on 05/20/2015 at 4:15:28 PM was conducted. The MDS nurse stated she had been in the position of MDS nurse for three days and was beginning to learn the MDS process. The nurse consultant stated coding on all MDS assessments should be accurate and a diagnosis for each medication received by a resident should be present.  An interview with the DON on 05/20/2015 at 4:51:40 PM was conducted. The DON stated she expects the MDS assessments to be done correctly, accurately and diagnoses should be included that reflect any medication received. The DON stated the facility has had a recent change in MDS nurses.	F 278	standard of classification for the assessment.  The Director of Nursing will provide to the Minimum Data Set nurse a copy of Omnicare Pharmacy's monthly Psychoactive Medications report which lists all residents on antipsychotics. By the 15th of every month for the remainder of year 2015, the Director of Nursing and/or Assistant Director of Nursing will conduct an audit of current residents on psychoactive medications to ensure the facility is accurately coding diagnoses on the MDS. If the monthly audit outcomes indicate that compliance is at 100%, then the MDS audits will be conducted quarterly. If 100% compliance is not met, then monthly MDS audits will continue until 100% compliance is met for six consecutive months. Audits will be maintained in a binder located in the MDS office. MDS audit outcomes will be reported in the QI meeting monthly by the MDS nurse.  The MDS nurse will conduct an in-service with the nursing staff on how to collect all pertinent information for the resident including diagnosis/indication with each medication order. Completion Date: 6/24/2015		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards	F 323		6/12/15	

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F 323	<p>Continued From page 6</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain safe water temperatures in 11 of 22 rooms on the skilled nursing halls. The findings included: During an observation on 5/18/15 at 2:50 PM the water temperature in the sink in resident room East 5 felt warm. The resident stated she did not notice the water was too hot. On 5/18/15 at 3:18 PM the Director of Environmental was contacted. After checking the calibration of the digital thermometer the water temperature in the resident room on East 5 was tested and found to be 121 degrees Fahrenheit. During an interview with the Director of Environmental on 5/18/15 at 3:20 PM he stated the temperature of the water was too warm and the water temperature should be less than 118 degrees Fahrenheit. Additional checks of water temperatures on 5/18/15 at 3:20 PM revealed both rooms 1 and 3 on the west hall had water temperatures of 121 degrees Fahrenheit. Through continued checking on west hall room 10 registered 120.8 degree Fahrenheit, room 9 registered 120.2, room 8 was 119.4, room 7 was 119.3, room 6 was 117.9, room 5 was 117.7, rooms 4 &amp; 3 were 117, room 2 was 116, and room 1 was 116.2. On the East hall the highest water temperature was found in room 10 which registered 115.9 degrees</p>	F 323	<p>The Albemarle maintenance director turned the water temperature down to 110 degrees Fahrenheit on the two water heaters that supply hot water to the resident rooms in skilled nursing on 05/18/2015 (day one of the survey). The Albemarle maintenance staff then purged the water lines to remove the hot water in the water lines on 05/18/2015.</p> <p>The Albemarle maintenance staff is now checking the water temperature daily at varying times to ensure that we are maintaining the proper temperature range of 100 to 116 degrees Fahrenheit throughout the day starting on 05/19/2015.</p> <p>The Albemarle's local plumbing contractor, came to the Albemarle on 05/20/2015 to check the hot water heater thermostats and circulating pumps in the skilled nursing area. Upon inspection, he could find no problems with the hot water heater thermostats or circulating pumps. He then met with the maintenance director and the surveyor on 5/20/2015 to explain that due to the location of the thermostat in the middle of the tank, the water on top of the tank was hotter than</p>		

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F 323	<p>Continued From page 7</p> <p>Fahrenheit. With continued checks the water temperatures on the East hall the temperatures continued to decrease and room 1 registered 108.3. The Director of Environmental Services was purging the system and the temperatures started to drop.</p> <p>During an interview with the Director of Environmental on 5/18/15 at 3:40 PM he stated the water temperature was monitored daily and recorded in the Water Temperature Log book. He also stated he had turned the water temperature down on the 2 water heaters located in a closet behind the fire door on the North hall. He reported he was letting the water run for an hour to help drain off the hot water.</p> <p>On 5/18/15 at 3:45 PM maintenance staff member #1 stated he took the water temperatures this morning before lunch as part of his normal morning duties as he did every morning and the water temperatures were not above the upper limit of 116 degrees Fahrenheit. He stated he checked the temperatures on Saturday morning, May 16, 2015 and Sunday morning, May 17, 2015 and on both days the temperatures were less than 116 degrees Fahrenheit. He provided a Water Temperature Log Sheet. He then explained he checked the water temperature in one random common area and one random resident's room daily.</p> <p>A review of the Temperature Log Sheets on 5/18/15 at 3:45 PM revealed no temperatures above 111 degrees Fahrenheit.</p> <p>On 5/18/15 at 3:45 PM the Director of Nursing (DON) was observed posting signs in each resident's room. The sign read "Do not use the hot water."</p> <p>On 5/18/15 at 4:25 PM the Executive Director stated she was not aware of any previous incidents of high water temperatures. She added</p>	F 323	<p>the water near the heating element.</p> <p>The maintenance director will bring to the monthly QI meeting the previous month's Skilled Nursing Water Temperature Logs which documents the temperature taken daily at varying times to add to the minutes of each monthly QI meeting.</p> <p>The temperature was lowered from 122 degrees Fahrenheit to 110 degrees Fahrenheit on 05/18/2015 (day one of survey). No harm resulted to any resident.</p>		



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F 323	<p>Continued From page 8</p> <p>that no baths or showers were given without a staff member present. She said that if there was a problem the Director of Maintenance would know what to do to correct the problem and that he was bleeding the water lines to bring the water temperature down. She stated they should check the system and monitor the water temperatures more frequently. She added that the DON was putting out notices. She stated that the residents needed help with taking a bath so they would not draw bath water alone and the only concern would be in the resident's room if they turned on just the hot water. She added that they had turned off the hot water in the resident's room and the DON informed the staff and alert residents plus she posted signs to remind everyone not to use the hot water.</p> <p>A review of the Water Temperature Sheets Log book on 5/18/15 at 4:45 PM revealed no temperatures above 111 degrees Fahrenheit were present for the past year.</p> <p>During an interview with NA #1 on 5/18/15 at 5:40 PM she stated if baths are not completed by 11:00 AM then there was no hot water left. She added that when she was scheduled to work on the 3:00 PM to 11:00 PM shift the water felt hot between 3:00 PM and 4:00 PM. She stated she had reported it to the Assistant Director of Nursing (ADON) who reported the information to the maintenance department. She reported this had only happened once a few months ago.</p> <p>During an interview with NA #6 on 5/18/15 at 5:42 PM she stated that NA #2 was the shower person today so all the showers scheduled for today were completed on the first shift. She added when she completed a shower for a resident she always tested the water with her hand prior to putting water on the resident. She added that if the water felt warm to her she added more cold</p>	F 323			

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F 323	Continued From page 9 because she knew the elderly residents were more sensitive to the water temperature. During an interview with the Director of Environmental at 5:50 PM on 5/18/15 he demonstrated the water temperature in the shower room was 102.1 degrees Fahrenheit. He reported the facility staff would continue to monitor the water temperatures throughout the night by having a maintenance person check the temperature at 9:00 PM plus have the night watchman to check the water temperatures again at mid night and between 3:00 and 4:00 AM on 5/19/15. He added the maintenance staff would continue to monitor the water temperature at least 3 times on 5/19/15. He stated he had contacted a plumber to come to check the water system. At 6:00 PM on 5/18/15 the Director of Environmental provided a copy of the updated facility policy titled Skilled Nursing Water Temperature Log Policy. The policy had changed to include the procedure that the water temperature reading would be taken at varying times each day and it included that the state-specific regulations would supersede the policy and must be followed. It then listed the state's temperature requirement of 100 degrees Fahrenheit to 116 degrees Fahrenheit. On 5/20/15 at 12:19 PM the owner of the plumbing company reported he checked the thermostats and the circulating pump and all were working correctly. He said due to the location of the thermostat in the middle of the tank that the water on the top of the tank was hotter than the water near the heating element so that may be the reason the water was hotter. He stated there were no mixing valves in this system. During an interview on 5/20/15 at 11:37 AM the DON stated there were no residents at the facility who were mentally confused but able to walk.	F 323			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE FOUNTAINS AT THE ALBEMARLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 TRADE STREET TARBORO, NC 27886</b>		
(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 323	Continued From page 10 She also stated the facility did not have any residents who were mentally confused but physically capable of turning on the water faucet in their room.	F 323			