STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

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CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a care plan for the use of an antipsychotic medication for one of one sampled residents on antipsychotic medications. (Resident # 41) The findings included: Resident # 41 was readmitted to the facility after a hospitalization for mental status changes on 6/9/15. Discharge orders dated 6/9/15 included Seroquel (antipsychotic medication) 25 milligrams twice a day. Review of the Minimum Data Set (MDS) dated	F 279	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the accuracy of the facts alleged or conclusion set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code Section 12909 and C.F.R. 405 1907. F 279	12/8/15

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

Electronically Signed | 12/01/2015

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F 279	Continued From page 1 6/16/15 for a Significant Change indicated Resident #41 was receiving antipsychotic medications in the last seven days. Review of the Care Area Assessments (CAAS) dated 6/16/14, for the CAA psychotropic drug use, revealed antipsychotic medication usage was checked, antianxiety and antidepressant were also checked. Review of "Analysis of findings:" Resident # 41 "is receiving 3 psychotropic meds. She had been on these long term. Her diagnosis to coorelate (sic) with these: depression and anxiety. She is at risk for side effects related to these medications. No side effects observed. Pharmacy review of meds monthly for effectiveness, possible dose reduction, side effects. Care Plan will be developed for this Care Area." Interview with MDS nurse coordinator on11/04/2015 at 3:05 PM revealed she missed the antipsychotic medication on the CAA. She would check the computer system to make sure the area was not care planned. Interview with MDS nurse coordinator on 11/04/2015 at 4:17 PM revealed she had not completed a care plan for psychotropic medications.	F 279	For the resident cited: o A care plan for resident #41, addressing the use of antipsychotic medications, will be developed and added to the comprehensive care plan for this resident. For other residents at risk: o A report from our electronic medical record software (AHT), listing all residents with physician orders for antipsychotic medications, will be generated and the care plans for all residents identified will be reviewed to determine if their comprehensive care plan includes a plan of care for antipsychotic use. (Note: the review indicated that all residents receiving antipsychotic medications had a care plan for antipsychotic use.) System changes (new practices, new policies, new forms etc) o The facility practice in which nursing leadership reviews - each morning, 5 days a week - all physician orders received within the last 24 to □ 72 hours, will continue. A care plan for any resident identified as having new or changed orders for antipsychotic medications will developed. o The Nursing leadership, including MDS staff, will be re-educated regarding the daily physician order review, generating the monthly AHT report of residents on antipsychotic medications, and the process for developing care plans as the resident care needs change.	

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F 279	Continued From page 2	F 279	How will we monitor for improvement: o Each week for the next 4 weeks, and then once each month for 12 months, a report from our electronic medical record software (AHT) showing all residents with physician orders for antipsychotic medications will be generated, and the care plans for those residents on antipsychotics will be audited to ensure they have a plan of care for antipsychotic use. o The results of the weekly and monthly audits of the care plans for all residents on antipsychotics will be presented to the Quality Management Team with QAPI at their monthly meeting for the next 12 months and the QMP with QAPI will modify the plan if the audits show an unfavorable trend.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		12/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 3 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to update the care plan of 1 of 1 resident with current interventions due to the resident's refusals of a splinting device. (Resident #92). The facility failed to update the care plan for interventions of adaptive eating equipment for two of three residents (Residents #49 and 104). The findings included: 1. Resident #92 was admitted to the facility on 4/12/13. Diagnoses included Dementia and chronic contractures. Review of the Minimum Data Set (MDS), a quarterly, dated 8/18/15 indicated no behaviors were exhibited by Resident #92 and no rejection of care occurred during the assessment timeframe. Resident #92 had communication problems and had moderate impairment with memory. This MDS indicated Resident #92 had functional limitation in range of motion on one side of the upper extremity. Review of the care plan with updates of 9/4/15 included a problem of skin breakdown risk due to impaired/decreased mobility. The update indicated a palm protector was to be used in the right hand while "awake" and a wash cloth was to	F 280	F 280 For the resident cited: o The care plan for resident # 92 will be revised to reflect current occupational therapy recommendations and resident wishes, for splinting devices. o The care plan will be updated for resident # 49 to include the need for a clear lap tray at every meal. o The care plan for resident #104 will be revised to include the need for a scoop dish to be provided at every meal. For other residents at risk: o Every resident will be screened by therapy staff for the potential need for adaptive equipment. Those for whom the screen indicates a potential need for adaptive equipment will then be evaluated by therapy for actual need of adaptive equipment. o If new adaptive equipment is required, or if existing adaptive equipment is to be continued, modified or discontinued per the resident evaluations, therapy will indicate their recommendations for adaptive equipment on physician orders. o Care plans for all residents determined to need adaptive equipment will be	

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F 280	Continued From page 4 be used in the right hand "while in bed." Review of the therapy communication form dated 7/31/15 Resident #92 was referred to therapy on 7/31/15 by a nurse due to upper body/multi contractures of right arm/hand. A telephone order dated 8/27/15 indicated occupational therapy was discontinued. The resident was to continue wearing the palm guard to maintain/prevent further contractures. Record review of the nurses' notes for the dates of 8/29/15 9/2/15, 9/3/15 and 9/6/15 revealed Resident #92 refused to wear the palm guard, would remove the palm guard and the wash cloth from her hand. Documentation of one removal by the resident caused bruising over her eye due to pulling on the palm guard with force. Observations on 11/04/2015 at 9:22 AM revealed Resident #92 was out of bed and seated in a wheelchair. The palm guard was on the tray table in front of the resident. Resident #92 held her right hand in a fist with her arm bent against her chest. Interview with aide #1 on 11/3/15 revealed the resident refused the palm guard. The resident also takes the palm guard off at will. 2. Resident #49 was admitted to the facility on 9/2/14 with diagnosis diagnoses that included Alzheimer's disease, gastro-esophageal reflux disease without esophagitis, and macular degeneration. The most recent Minimum Data Set (MDS) assessment dated 8/21/15 revealed Resident #49 required extensive assistance with	F 280	revised to include new and or changed interventions. System changes: o A system for determining the need for adaptive equipment, communicating that need to the necessary departments, and updating the care plans and / or kardex, will be outlined. The system is: Going forward, for each resident admitted to the facility or referred to therapy for screening, therapy will determine the need for adaptive equipment and will complete physician orders stating their recommendations. Therapy will also send an email to the dietary manager, dietician, MDS, and Administrator stating their recommendations. The dietary manager will then ensure the adaptive equipment is available for meals, the dietitian will monitor weight per facility policy, the MDS will update the care plan and kardex for the use of adaptive equipment, and the Administrator will ensure all steps are followed timely. o When therapy records new recommendations for adaptive equipment on physician order forms, they will train the nursing staff caring for the resident, the SDC, and the appropriate nurse manager, on the proper use of the required adaptive equipment. o A list of the residents, and their needs, who require adaptive equipment is generated by the dietary manager whenever orders are added or changed	

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F 280	Continued From page 5 eating. The MDS further indicated resident #49 was cognitively impaired. Review of physician order dated 10/2/15 revealed Resident #49 to have lap tray placed on wheelchair for all meals to aid feeding. Review of Resident #49 nutritional evaluation dated 8/20/15 revealed a physician order for a clear lap tray as an adaptive dining device. Review of Resident #49 care plan last updated 9/10/15 indicated a "problem" of potential for weight loss related to leaving 25% of food uneaten at most meals. The goals included, Resident #49 would eat at least 50% of most meals served, and Resident #49 would maintain current weight or gain weight over the next 30 days. The approaches were not updated to include a clear lap tray at meals. Observation on 11/2/15 at 11:47 am revealed Resident #49 was eating her lunch from her meal tray which was placed on the dining table. The resident's meal cared reveled the resident needed to use a clear lap tray. No lap tray was observed during the meal. Observation of Resident #49 meal card revealed the resident needed to use a clear lap tray. No lap tray was observed during the meal. On 11/4/15 at 11:50 am, Resident #49 was observed to have her meal on a clear lap tray. The resident's milk and puree cake were observed on the dining table directly in front of the resident. Resident #49 was observed to reach over her lap tray to retrieve the items located on the dining table. The resident was observed having difficulty reaching over her lap tray to retrieve her milk and puree cake. Observation on 11/4/15 at 8:51 am revealed Resident #49 to be eating in her room. The resident's meal tray was observed to be on her bedside table. The resident's meal card indicated	F 280	and this list is available to staff who assist with meals. o The Therapy Department, Dietary, Registered Dietitian, and Nurse Leadership will be educated on the newly defined system for communicating the need for, and implementing use of, adaptive equipment. o Nursing staff will be educated on the correct use of adaptive equipment and the location of the list which details which residents need which equipment. How will we monitor for improvement: o Random audits of 20% of the residents with orders for adaptive equipment will be conducted each week for 4 weeks, and then monthly for 3 months. o The results of these weekly and monthly audits will be presented to the Quality Management Team with QAPI at their monthly meeting for the next 3 months and the QMT with QAPI will modify the plan if the audits show unfavorable trends and / or continued non-compliance.	

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F 280	Continued From page 6	F 280		

the resident needed to use a clear lap tray. No lap tray was observed attached to Resident #49's wheelchair.
Observation of Resident #49 on 11/4/15 at 5:00 pm revealed Resident #49 eating at the dining table. Resident was being assisted with dining by nursing assistant (NA) #4. No clear lap tray was observed attached to Resident #49's wheelchair.
Interview with NA#4 assisting Resident #49 with dining on 11/4/15 at 5:00 pm stated Resident #49 sometimes had the clear lap tray and sometimes didn't. She stated she did not typically work with Resident #49 and was unaware of where the lap tray was.
Interview with the MDS coordinator on 11/5/15 at 9:23 am revealed dietary was responsible for updating care plans to include adaptive equipment. The therapist went to the dietician and the dietician included it on the care plan. Although she indicated she was not responsible the MDS coordinator indicated adaptive equipment should be included in the care plan.
Interview with the Dietician on 11/5/15 at 9:36 am revealed she was responsible for adding interventions to resident care plans that dealt with weights or chronic conditions regarding nutrition. The dietician stated she would add interventions in regards to adaptive equipment. . The dietician implied that when the intervention included assistance was needed, she would consider that to include feeding assistance or feeding equipment. The type of equipment was placed on the resident's meal card but not on the care plan.
Interview with the Administrator on 11/5/15 at 8:20 am stated his expectation that recommendations for adaptive equipment be followed. He further indicated that his expectation was that adaptive equipment be used properly. Staff were to look at

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F 280	Continued From page 7	F 280		

resident meal cards to ensure adaptive equipment needs were met. Staff were expected to communicate resident's needs or difficulty with recommended equipment to ensure therapy could put interventions into place.
3. Resident #104 was admitted to the facility on 4/1/15 with diagnoses that included, dementia without behavioral disturbance and dysphagia. The most recent Minimum Data Set (MDS) assessment dated 7/30/15 indicated Resident #104 required extensive assistance for eating. The MDS further indicate Resident#104 was cognitively impaired.
Review of Resident #104 physician order dated 10/1/15 revealed, "occupational therapy evaluation only with placement of scoop dish (adaptive dining plate) for independent self-feeding" and "use scoop dish with all meals. "
Review of Resident #104 occupational therapy (OT) evaluation dated 10/1/15 indicated Resident #104 had difficulty feeding himself. The evaluation stated a scoop dish was recommended for all meals.
Review of Resident #104's care plan updated 10/28/15 indicated a "problem" of being unable to perform any of his own care, dressing, bathing, and toileting without extensive assistance of staff. Due to cognitive loss Resident #104 was unable to follow instructions consistently. The goal stated Resident #104 would be able to maintain his ability to feed himself. The approaches did not include the use of adaptive equipment.
Observation on 11/2/15 at 11:57 am revealed Resident #104 to be seated in front of a scoop dish. The scoop dish was observed to be turned backwards with the scoop side of the dish facing the resident. The scoop dish contained broccoli, mash potatoes and a bowl of soup. The bowl of

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F 280	Continued From page 8	F 280		

soup was observed to be in the middle of the scoop dish. Resident #104 was observed eating the food around the bowl located in the center of the scoop dish. The resident was being provided assistance by the Assistant Director of Nursing (ADON).
Observation on 11/4/15 at 8:27 am revealed Resident #104 to be assisted with dining by nursing assistant (NA) #6. NA#6 was observed to have Resident #104's meal tray directly in front of her on a bedside table. Resident #104 was observed to be to the left of staff. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the staff
Interview with the MDS coordinator on 11/5/15 at 9:23 am revealed dietary was responsible for updating care plans to include adaptive equipment. The therapist went to the dietician and the dietician included it on the care plan. Although she indicated she was not responsible the MDS coordinator indicated adaptive equipment should be included in the care plan.
Interview with the Dietician on 11/5/15 at 9:36 am revealed she was responsible for adding interventions to resident care plans that dealt with weights or chronic conditions regarding nutrition. The dietician stated she would add interventions in regards to adaptive equipment. The dietician implied that when the intervention included assistance was needed, she would consider that to include feeding assistance or feeding equipment. The type of equipment was placed on the resident's meal card but not on the care plan.
Interview with the Administrator on 11/5/15 at 8:20 am stated his expectation that recommendations for adaptive equipment be followed. He further indicated that his expectation was that adaptive equipment be used properly. Staff were to look at

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F 280	Continued From page 9 resident meal cards to ensure adaptive equipment needs were met. Staff were expected to communicate resident's needs or difficulty with recommended equipment to ensure therapy could put interventions into place.	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to have two persons perform transfers for 1 of 4 sampled residents (Resident #117) and failed to prevent spillage of hot liquids to prevent burns for 1 of 1 sampled residents (Resident #117). The Immediate Jeopardy started on 7/29/15 when Resident #117 sustained a C2 (cervical spine) fracture and a dislocated shoulder as a result of a fall from an unsafe transfer by mechanical lift. The Immediate Jeopardy was removed on 11/6/15 at 1:45 am when the facility provided a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of G (actual harm that is not Immediate Jeopardy) due to example 2. The findings included:	F 323	F 323 Re: a fall with fracture For the resident cited o A Plan of Correction addressing a fall that occurred with a resident #117 on July 29, 2015 was prepared on 7/29/15. This plan of correction (7.29.15) included: Immediate care of the injury was performed, the attending physician and family member were notified. The resident was sent to the hospital where he remained in observation for 24 hours for a fracture at C2. This was completed 7.29.15 The lift and lift pad involved in the fall were removed from service until they	12/8/15

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F 323	Continued From page 10	F 323		

1. Resident #117 was admitted to the facility on 4/1/15 with diagnoses that included Heart Failure, atrial fibrillation, dysphagia, and anxiety disorder.

Review of the admission minimum data set (MDS) assessment dated 6/8/15 revealed Resident #117 required extensive assistance with bed mobility and transfer with the use of 2 staff. The MDS further indicate Resident #117 was moderately cognitively intact.

Review of the care area assessment (CAA) dated 4/8/15 revealed Resident #117 was currently non ambulatory, dependent on staff for transfer with using maxi lift (total mechanical lift) by nursing assistants (NA). The CAA stated, "Therapy was working on standing transfers but report (Resident #117) was not able."

Review of Resident #117 care plan updated 6/8/15 revealed no care plan in regards to transfers.

Review of the Kardex (electronic information used for a resident care guide) indicated Resident #117 required 2 + staff for transfers.

Review of Resident #117 incident report dated 7/29/15 revealed Resident #117 had a fall in his room which resulted in injury. The narrative of the incident stated, "Both hall NAs (nursing assistants) (NA#1 and NA#2) were in Resident #117's room. NA#1 and NA#2 had Resident #117 on the total mechanical lift. The right upper body strap came undone and Resident #117 fell about 1-2 feet to the floor. " The incident report continued with Resident #117 had approximately 7cm (centimeters) in diameter round knot on right side of his head and a small abrasion under the

could be inspected for mechanical problems. None were found and the lift was put back into service. This was completed 7.29.15.

A full investigation into the root cause of this fall with injury was conducted: The findings showed the resident was care planned for a 2 person assist, and this information was also on the SmartChart (the instructions for providing care that the CNAs and Nurses see each time they provide ADL assistance, incontinence care, etc.) However, one CNA attempted a transfer with a mechanical lift with resident #117 by herself. She was suspended immediately after the fall on 7.29.15. The root cause analysis showed there was no fault with the lift or lift pad, and that the root cause of the accident was the CNA, who failed to follow facility procedure. The CNA was terminated on 7.31.15 without ever returning to work.

o Upon resident #117's return to the facility from the hospital a full assessment was attempted, although he refused a skin check, saying he was fine. This was completed 7.30.15.
o The care plan was revised to include a neck collar and new pain meds. Use of a mechanical lift for transfers was added to the care plan, as was the need for a 2 person assist. The care plan modifications were completed by the MDS coordinator on 8.2.15.
o As of 11.5.15, this resident # 117 has suffered no more falls during transfer with a mechanical lift. His neck collar has

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 11 knot on back of his bead. Trace amounts of blood were noted. The medical director was notified and ordered Resident #117 to the emergency room for evaluation and treatment. The immediate post-incident action stated, "Investigating why lift pad came undone and reeducated staff on proper ways to hook lift pad to lift." The narrative of investigation stated, "Both the lift and the sling were in working order. Re-education with all staff on proper use of mechanical lift and safe transfer procedure. Random audits of transfer begun. (Resident #117) is a hands on two person transfer." Their investigation indicated that all staff were re-educated on the mechanical lift with the use of 2 people on 7/30/15. Review of physician order dated 7/29/15 stated send Resident #117 to the emergency room for evaluation and treatment of post fall. Hospital discharge summary dated 7/30/15 indicated Resident #117 was sent from the nursing home for a fall. Resident #117 had a CT (x-ray procedure) and magnetic resonance imaging (MRI) of the neck which showed a C2 fracture. The discharge summary further indicated resident #117's left shoulder x-ray showed he had a dislocated shoulder. Review of Resident #117's significant change MDS assessment dated 8/7/15 revealed a significant change from Resident #117's 6/8/15 MDS assessment for activities of daily living (ADLs). The areas of change indicated resident went from extensive assistance with one person assistance to total assistance with the use of 2 people in the areas of locomotion. Resident #117 went from total dependence with one person	F 323	been removed. For other residents at risk: o All mechanical lifts and pads were removed from service until they could be inspected to identify mechanical problems or wear / tear concerns. All lifts and lift pads passed this inspection and were put back into service. This was completed by the Administrator and the Maintenance Director on 7.29.15 o Observations of all other residents who require mechanical lifts for transfers were made. No other transfers were done inappropriately (using proper technique and following facility procedure for knowing where to look to find the level of assistance needed (1 person or two persons). This was completed by the Staff Development Coordinator on 7.29.15. o Observations of the other residents who require mechanical lifts for transfers were made again. No other transfers were done inappropriately (using proper technique and following facility procedure for knowing where to look to find the level of assistance needed (1 person or two persons). This was completed the second time on 11.5.15. o The care plans and SmartChart information for all residents who are transferred using a mechanical lift, were reviewed to ensure the care plan for the level of assistance (1 or two person) was correct, and the SmartChart information matched the care plan instructions. This was completed by the MDS Coordinator	

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

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F 323	Continued From page 12 physical assistance to total dependence with two person assistance in the area bathing self-performance. Resident #117 went from not steady with balance (only able to stabilize with staff assistance) to the activity did not occur with moving from seated to standing position. Resident #117 went from not steady (only able to stabilize with staff assistance) to the activity did not occur in the areas of balance: moving on and off the toilet. Review of Resident #117's physician order dated 9/4/15 stated may discontinue cervical collar on 9/9/15. Interview with NA#1 on 11/4/15 at 4:27pm stated on 7/29/15, she and NA#2 were in the process of completing their last rounds for their shift. NA#1 and NA#2 had to lay down Resident #117 and his roommate that were both 2 person assist/transfer. NA#1 indicated she was in the process of providing care to Resident #117's roommate when NA#2 went ahead and hooked Resident #117's lift pad up to the mechanical lift. While NA#2 was taking Resident #117 up in the total mechanical lift one of the four hooks from the lift pad came undone. NA#1 stated the hook that goes around Resident #117's right shoulder had come undone. As a result Resident #117 went backwards and hit his head on the floor. NA #1 indicated she told NA#2 to stay with Resident #117 so NA#1 could get assistance. The Assistant Director of Nursing (ADON) assisted with getting Resident #117 off the floor. NA#1 revealed she and NA#2 were supposed to have 2 people with the total mechanical lift when hooking the resident up by the lift pad. NA#2 was the only staff transferring Resident #117 with the mechanical lift.	F 323	on 7.30.15. o The care plans and SmartChart information for all residents were reviewed again to ensure the care plan for the level of assistance for all ADLs is correct, and the SmartChart information matched the care plan instructions. This was completed for the second time on 11.5.15. System changes: o The CNA who failed to follow SmartChart and care plan instructions on the level of assistance needed for a transfer of resident #117 was suspended immediately after the incident (7.29.15), pending investigation. She was terminated on 7.31.15 without ever returning to work. o Direct care staff were educated on the proper lift procedures, including the need for 1 or 2 persons to assist. The hand out was entitled "Steps to Safe Transfer". The inservice and the handout stated that "If a resident requires 2 person assist, 2 staff members must be present during the entire lift procedure". This was completed on 7.29.15. Direct care staff were not allowed to transfer any resident until they had been educated which included a return demonstration. This was completed on 7.29.15. Any employee who failed to pass the return demonstration was not allowed to transfer any resident using a mechanical lift until he / she passed the return	

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F 323	Continued From page 13 NA#2 was unavailable for interview. Interview with the assistant director of nursing (ADON) on 11/5/15 at 7:48am revealed she was approached by NA#1 that communicated Resident #117 had fallen out of the mechanical lift. The ADON indicated she went into Resident #117's room and observed Resident #117 on the floor with the total mechanical pad underneath him. Both leg straps were hooked and one shoulder strap of the lift pad was hooked. The hook for the right shoulder strap of the lift pad was observed to be unhooked. The ADON stated she lowered Resident #117 the rest of the way to the floor due to his body still being slightly propelled by the connected lift pad. The ADON stated she rolled Resident #117 to see the back of his head to determine where the blood was coming from. Resident #117 was upset as evidenced by cursing at nursing staff and stated he said he hurt all over. The ADON stated when she questioned the 2 NAs about what had occurred it was communicated that NA#1 was providing care to Resident #117's roommate and NA#2 was putting Resident #117 in the bed also. The NAs stated they both were in the room but both were not with the lift at the same time for 2 person transfer. ADON revealed staff were instructed during training to use 2 people for a total lift. Even if one NA was doing all the work the other NA was to ensure that the hooks clicked into place (when you pull it into place they click). The ADON stated "we terminated (NA#2) following the incident for not following company policy." Interview with the Administrator on 11/5/15 at 8:20am revealed he was made aware of the incident involving Resident #117's fall on 7/29/15. Upon an internal investigation it was discovered that NA#1 was helping Resident #117's	F 323	demonstration. None failed to pass. This was completed on 7.29.15. o All nurses and CNAs were inserviced again, using the same "Steps to Safe Transfer" instructions and handout that were used in July 2015 training efforts, and including return demonstration. This inservice was again focused on how to safely use a mechanical lift to transfer a resident. As part of this inservice, a new line was added to the handout, and the discussion, that reads "Staff will identify if a resident is a 1 or 2 person lift, by looking at the care plan and / or the SmartChart AHT Module (commonly known as the "kardex" or "kiosk"). This was initiated for the second time on 11.5.15 and completed 11.9.15. Again no employee was allowed to transfer a resident until he / she had been re-educated, including return demonstration, and any employee who failed to pass the return demonstration was not allowed to transfer residents until they had passed the return demonstration. This was initiated for the second time on 11.5.15 and completed 11.9.15. o New employees are trained on proper procedures for transferring with mechanical lifts, including return demonstration, during their orientation period and annually. Going forward, spot audits will be conducted on all new direct care staff x 3 during their first 3 weeks of employment. This was completed on	

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F 323	Continued From page 14 roommate and NA#2 took it upon herself to transfer Resident #117 even though he needed the assistance of two persons. The Administrator indicated that the internal investigation and inspection of the mechanical lift revealed no mechanical error with the lift. The Administrator described the lift pad as having slings that had tabs that fastened to the total mechanical lift. The tabs were described as hook and eye tabs. The Administrator stated when "you pull down on the tab it makes a distinct pop sound that indicates it is in place and properly hooked." The Administrator stated NA#2 was terminated as a result of not following company guidelines as it related to operating the lift with 2 people. Resident #117 was described by the Administrator as a large man who required 2 staff to ensure his safety during a transfer utilizing the mechanical list. The Administrator stated it was his expectation that staff operated the mechanical lift properly and the resident was safe during the transfer. It was further his expectation that staff followed training and guidelines when transferring any resident. The Administrator was notified of Immediate Jeopardy on 11/5/15 at 1:49pm for example 1. The facility provided the following credible allegation of compliance: 1. Corrective action for resident affected. Immediate care of the injury was performed, the attending physician and family member were notified. The resident was sent to the hospital where he remained in observation for 24 hours for a fracture at C2. This was completed by the charge nurse on 7/29/15. The lift and lift pad were removed from service until they could be inspected for mechanical problems. None were found and the lift was put back into service. This was completed by the	F 323	7.29.15, with ongoing spot audits until October 2015. o New employees will continue to be trained on proper procedures for transferring with mechanical lifts, including return demonstration, during their orientation period and annually. Spot checks on all new direct care staff x 2 during their first 3 weeks of employment. This was reinitiated 11.5.15. How will we monitor for improvement: o Random observations of lift transfers of residents requiring mechanical lifts, was conducted between July 2015 and October 2015. All staff passed the random observation. This was completed in October 2015. o Random observations of 10% of residents requiring transfer using a mechanical lift will be conducted 5 times per week for 4 weeks, and then weekly another 4 weeks. During the transfers, the staff will be asked "where do you find the information regarding the number of persons required for a transfer". Any staff who cannot show compliance with the transfer technique, or who does not know where to look for level of assistance required, will not transfer any residents until the staff member can show compliance through return demonstration. This was initiated in November and will continue for 4 weeks. o The Staff Development Coordinator will present the results of the observations with the QMP with QAPI team members, who are present as part of the IDT, during	

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F 323	Continued From page 15 administrator and maintenance director on 7/29/15. A full investigation into the root cause of this fall with injury was conducted: The findings showed the resident was care planned for a 2 person assistance, and this information was also on the SmartChart (the instructions for providing care that the CNAs (nursing assistants) and Nurses see each time they provide ADL assistance, incontinence care, etc.) However, one CNA attempted a transfer with a mechanical lift with resident #117 by herself. She was suspended immediately after the fall on 7.29.15. The root cause analysis showed there was no fault with the lift or lift pad, and that the root cause of the accident was the CNA, who failed to follow facility procedure. The CNA was terminated, without ever returning to work. This was completed by the administrator, and director of nursing on 7/29/15. Upon resident #117's return to the facility, a full assessment was attempted, although he refused a skin check, saying he was fine. This was completed by the charge nurse on 7/30/15. The care plan was revised to include a neck collar and new pain medications. Use of a mechanical lift for transfers was added to the care plan, as was the need for a 2 person assistance. This was completed by the MDS Coordinator on 8/2/15. 2. Corrective action for residents with the potential to be affected Observations of all other residents who required mechanical lifts for transfers were made. No other transfers were done inappropriately (using proper technique and following facility procedure for knowing where to look to find the level of assistance needed (1 person or two persons).This was completed by the Staff Development Coordinator on 7/29/15.	F 323	the morning meeting, 5 times a week for four weeks, then weekly for four weeks. The results will then be shared with the QMP with QAPI team monthly and included in the meeting minute notes. Any unfavorable trends or continued non-compliance will be addressed by the QMP with QAPI team, the plan revised as needed, the appropriate staff will be inserviced, and the monitoring will begin again (observations of 10% of residents needing lift transfers 5 times a week for four weeks). o For a period of 6 months and as needed after 6 months, the DOO will be present for each QMP with QAPI team meeting, which meets monthly. If the team is not following the facility guidelines in performing their functions, additional inservice will be conducted. Re: Coffee burn Actions taken for the resident cited: o The Restorative Nursing Aide (RNA #3) immediately used an extra clothing protector to absorb the liquid. This was completed 7.14.15 o RNA #3 immediately took the resident to his room and informed the charge nurse who immediately did an evaluation of #117's thigh. The charge nurse notified the wound nurse who assessed the resident, and the charge nurse contacted the family. The wound nurse contacted the physician and obtained orders. The wound nurse applied treatment to the blister. This was completed 7.14.15.	

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F 323	Continued From page 16 All mechanical lifts and pads were removed from service until they could be inspected to identify mechanical problems or wear/tear concerns. All lifts and lift pads passed this inspection and were put back into service. This was completed by the administrator and maintenance director on 7/29/15. The care plans and SmartChart information for all residents who were transferred using a mechanical lift, were reviewed to ensure the care plan for the level of assistance (1 or two person) was correct, and the SmartChart information matched the care plan instructions. This was completed by the MDS Coordinator on 7/30/15. The care plans and SmartChart information for all residents were reviewed to ensure the care plan for the level of assistance for all ADLs was correct, and the SmartChart information matched the care plan instructions. This was completed by the administrative nurses on 11/5/15. Observations of the other residents who required mechanical lifts for transfers were made. No other transfers were done inappropriately (using proper technique and following facility procedure for knowing where to look to find the level of assistance needed (1 person or two persons). This was completed by the administrative nurses on 11/5/15. 3. Measures/systems that were put into place to ensure the deficient practice does not occur again. Direct care staff were educated on the proper lift procedures, including the need for 1 or 2 persons to assist. The hand out was entitled "Steps to Safe Transfer". The inservice, and the handout stated that "If a resident requires 2 person assist, 2 staff members must be present during the entire lift procedure". This was completed by the Staff Development Coordinator on 7/29/15.	F 323	Actions taken for other residents potentially at risk: o All current residents will be evaluated by therapy or nursing, for safe consumption / risks associated with consumption of hot beverages using the Hot Beverage Risk Assessment. o Results of the Hot Beverage Risk Assessment will be evaluated, and interventions implemented accordingly, by the ITD which includes the MDS Coordinator, Social Worker, Therapy Manager, Activities Manager, Dietary, Treatment Nurse and either the DON or ADON. The interventions will be entered on the resident plan of care and included in the SmartChart instructions (commonly known as the kiosk or kardex. o All future residents will be assessed for risk of hot beverages on admission and quarterly. System changes to ensure the deficient practice will not occur: o A new assessment tool, Hot Beverage Risk Assessment will be added to the assessments that are automatically performed on admission, quarterly, and as needed. o The Hot Beverage Risk Assessment will be added as a line item to our “5 Day Checklist”. This checklist is reviewed by the IDT, along with the medical record, of all new admissions for each of the 5 days after their admission, to ensure that all required assessments, forms, orders, etc	

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F 323	Continued From page 17 Direct care staff were not allowed to transfer any resident until they had been educated which included a return demonstration. Any employee who failed to pass the return demonstration was not allowed to transfer any resident using a mechanical lift until he/she passed the return demonstration. None failed to pass. New employees are trained on proper procedures for transferring with mechanical lifts, including return demonstration, during their orientation period and annually. Going forward, spot audits will be conducted on all new direct care staff x 3 during their first 3 weeks of employment. All nurses and CNAs will be re-inserviced, using the same "Steps to Safe Transfer" instructions and handout, and including return demonstration. This inservice will again be focused on how to safely use a mechanical lift to transfer a resident. As part of this inservice, a new line was added to the handout, and the discussion, that reads "Staff will identify if a resident is a 1 or 2 person lift, by looking at the care plan and / or the SmartChart AHT Module (commonly known as the "kardex" or "kiosk"). This will be started by the administrative nurses on 11/5/15. No employee will be allowed to transfer a resident until he / she has been re-educated, including return demonstration, and any employee who fails to pass the return demonstration will not be allowed to transfer residents until they have passed the return demonstration. Validation of the credible allegation of compliance was conducted on 11/6/15. The inservice information was reviewed which included the use of the total lift, safety precautions to take, ensure the clip "clicks" , and where to find the information regarding how many staff required to transfer a resident. Direct care staff and nurses	F 323	are complete within 5 days of admission. o Therapy and nursing will be educated by the SDC on administering this tool, and on implementing the interventions determined by the IDT. Plans to monitor its performance to make sure the solutions are sustained. o A corporate representative (the Director of Operations and the Direct of Reimbursement Services) will review the Hot Beverage Risk Assessments on all current residents, to ensure all residents were assessed, and the interventions were included on the care plan and SmartChart (commonly known as the kiosk or the kardex), by 12.8.15. o Observations of 10% of residents who had recommendations / care plan changes, based on the Hot Beverage Risk Assessment, will be conducted each week x 4 weeks, and monthly for 3 months. The results of the audits will be presented to the Quality Management Team with QAPI each month for 3 months by the Director of Nursing and the QMT with QAPI will make changes to the plan if unfavorable trends, and / or continued non-compliance are evident.	

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F 323	Continued From page 18	F 323		

were interviewed concerning the inservice information. Interviews were conducted with administrative staff regarding the plan for education for staff not currently working. A plan was in place for the weekend to ensure staff would receive inservice training before working. Observation of direct care staff using a mechanical lift for a total care resident revealed no resident safety concern during transfer.
2. Resident #117 was admitted to the facility on 4/1/15 with diagnoses that included Heart Failure, atrial fibrillation, dysphagia, and anxiety disorder.

Review of the admission minimum data set (MDS) assessment dated 4/8/15 revealed Resident #117 required extensive assistance with eating. The MDS further indicated Resident #117 was moderately cognitively impaired.

Review of Resident #117's Occupational Therapy (OT) discharge summary dated 5/13/15 indicated resident was able to grasp 12 pounds with his right hand. The goal "the patient will perform self-feeding with adaptive equipment as needed and minimal assistance" was documented as met. The discharge plans and instruction stated the resident was discharged to restorative nursing program for self-feeding and range of motion/strength.
Review of Resident #117's restorative nursing care plan dated 5/22/15 indicated a program for eating/swallowing at a frequency of 6 days a week. The goal indicated Resident #117 was to maintain current level of function to feed self. The interventions included position upright in the broda chair, provide verbal cues for positioning and use utensils in the right hand. The care plan further indicated Resident #117 needed verbal cues and supervision.

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F 323	Continued From page 19	F 323		

Review of Resident #117's incident report dated 7/14/15 revealed Resident #117 had a 1st degree burn as a result from scalding/spillage of hot coffee. The narrative of the incident stated, "Resident spilled coffee on his lap during breakfast." The note continued that resident #117 sustained a medium sized red blister areas in his inner left thigh after the spill. The medical doctor was notified and the wound nurse was advised for treatment. The investigation concluded the temperature of the coffee in the dining area was set to 170 degrees Fahrenheit (F) prior to the spill and that the temperature was reduced down to 160 degrees F.

Physician order dated 7/14/15 stated to administer silver sulfadiazine 1% to the burn qd (daily) x 3 days and fax update.

Physician order dated 7/14/15 stated to discontinue silver sulfadiazine, and to use aquacel foam to blister on the left upper thigh.

Nursing notes indicated a burn to the left upper leg resolved as of 10/2/15.

Interview with restorative nursing assistant (RNA) #3 on 11/4/15 at 3:24 pm revealed on 7/14/15 Resident #117 was assigned to restorative for breakfast. Resident #117 was independent with drinking at the time she was providing restorative care. RNA#3 stated she had prepared the resident's coffee in a styrofoam cup. She stated she had put some ice in the coffee to cool it. She further indicated that she had put a lid on the styrofoam cup with a straw. She revealed Resident #117's grip was better with the cup than with a mug. On 7/14/15 Resident #117 had reached for his coffee and it spilled in his lap. The coffee was spilling though the straw and the lid had not come off.

Interview with the treatment nurse on 11/4/15 at 3:34 pm revealed she was involved with resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

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F 323	Continued From page 20	F 323		

#117 care following the incident in which he sustained a burn from spilling coffee. The treatment nurse stated she was told by Restorative NA #1 that Resident #117 had the coffee for a little while and it shouldn't have been that hot. When the treatment nurse took Resident #117's pants off to assess him she found a blister on his inner upper left thigh. The treatment nurse stated the aquacel foam kind of debrided the burn and resulted in the wound taking time to heal. The wound Nurse estimated the area to be 0.6 to 0.7 centimeter in size.

Interview with the Therapy Director on 11/04/15 at 4:30 pm revealed he had worked with Resident #117 prior to releasing him to restorative nursing. OT indicated when Resident #117 had been released to restorative nursing, Resident #117 was drinking coffee with handle/standard cup and had never had an issue. OT indicated he would not have recommended a styrofoam cup for Resident #117 due to it being flimsy.

Interview with the ADON on 11/5/15 at 7:56am indicated she did not see the incident occur. Restorative NAs were trained by OT when a resident is released from OT and are monitored by OT and the MDS Nurse.
In a continued interview on 11/5/15 at 9:44am, the Therapy Director revealed the therapist put the goals in place for the restorative aids. Occasionally he would conduct spot checks with the restorative aids to ensure that they were following the program. The weekly meetings were comprised of MDS and restorative aids. He revealed he would occasionally attend the weekly meetings. The restorative NAs would sign off on the program when OT provided training. The type of cup to be used was not included in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 21 plan because Resident #117 did not require an adaptive cup. When the resident was being provided restorative care he had fairly good range of motion at that time. The Therapy Director stated that he was not a part of the investigation to determine what type of cup was being used at the time of the incident. If restorative nursing noticed there was a decline of the resident ability to hold a regular cup they needed to come to him so recommendations for another type of cup could be assessed. Interview with the Administrator on 11/5/15 at 8:20am revealed he was made aware that Resident #117 had spilled coffee on himself which resulted in a burn. The Administrator stated Resident #117 was able to use the cup independently at that time but he was unsure of what kind.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to follow physician orders and therapy recommendations for 2 of 3 sampled residents (Resident #49 and Resident #104) who required adaptive dining equipment. The findings included: 1. Resident #49 was admitted to the facility on 9/2/14 with diagnosis diagnoses that included Alzheimer ' s disease, gastro-esophageal reflux disease without esophagitis, and macular	F 369	F 369 For the resident cited: o A clear lap tray will be provided to resident # 49 at every meal. o A scoop dish will be provided to resident #104 at every meal and will be used appropriately. For other residents at risk: o Every resident will be screened by	12/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 369	Continued From page 22 degeneration. The most recent Minimum Data Set (MDS) assessment dated 8/21/15 revealed Resident #49 required extensive assistance with eating. The MDS further indicated resident #49 was cognitively impaired. Review of physician order dated 10/2/15 revealed Resident #49 to have lap tray placed on wheelchair for all meals to aid feeding. Review of Resident #49 nutritional evaluation dated 8/20/15 revealed a physician order for a clear lap tray as an adaptive dining device. Review of Resident #49 care plan last updated 9/10/15 indicated a "problem" of potential for weight loss related to leaving 25% of food uneaten at most meals. The goals included, Resident #49 would eat at least 50% of most meals served, and Resident #49 would maintain current weight or gain weight over the next 30 days. The approaches were not updated to include a clear lap tray at meals. Observation on 11/2/15 at 11:47 am revealed Resident #49 was eating her lunch from her meal tray which was placed on the dining table. The resident ' s meal cared reveled the resident needed to use a clear lap tray. No lap tray was observed during the meal. Observation of Resident #49 meal card revealed the resident needed to use a clear lap tray. No lap tray was observed during the meal. On 11/4/15 at 11:50 am, Resident #49 was observed to have her meal on a clear lap tray. The resident ' s milk and puree cake were observed on the dining table directly in front of the resident. Resident #49 was observed to reach over her lap tray to retrieve the items located on the dining table. The resident was observed having difficulty reaching over her lap tray to retrieve her milk and puree cake. Observation on 11/4/15 at 8:51 am revealed	F 369	therapy staff for the need for adaptive equipment and any resident for whom the screen indicated a potential need for adaptive equipment will evaluated by therapy staff for actual need. Therapy will record their recommendations on physician order forms if new adaptive equipment is required or if existing adaptive equipment is to be continued, modified or discontinues. o Care plans for all residents determined to need adaptive equipment will be revised to include new and or changed interventions. System changes (new practices, new policies, new forms etc) o A system for determining the need for adaptive equipment, communicating that need to the necessary departments, and updating the care plans and / or kardex, will be outlined. The system is: Going forward, for each resident admitted to the facility or referred to therapy for screening, therapy will determine the need for adaptive equipment and will complete physician orders stating their recommendations. Therapy will also send an email to the dietary manager, dietician, MDS, and Administrator stating their recommendations. The dietary manager will then ensure the adaptive equipment is available for meals, the dietitian will monitor weight per facility policy, the MDS will update the care plan and kardex for the use of adaptive equipment, and the Administrator will ensure all steps are	

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F 369	Continued From page 23 Resident #49 to be eating in her room. The resident's meal tray was observed to be on her bedside table. The resident's meal card indicated the resident needed to use a clear lap tray. No lap tray was observed attached to Resident #49's wheelchair. Observation of Resident #49 on 11/4/15 at 5:00 pm revealed Resident #49 eating at the dining table. Resident was being assisted with dining by nursing assistant (NA) #4. No clear lap tray was observed attached to Resident #49's wheelchair. Interview with NA#4 assisting Resident #49 with dining on 11/4/15 at 5:00 pm stated Resident #49 sometimes had the clear lap tray and sometimes didn't. She stated she did not typically work with Resident #49 and was unaware of where the lap tray was. During an interview and observation with the therapy director on 11/4/15 at 5:07 pm revealed Resident #49 was to have a clear lap tray attached to her wheelchair at each meal and did not have it. 2. Resident #104 was admitted to the facility on 4/1/15 with that included, dementia without behavioral disturbance, and dysphagia. The most recent Minimum Data Set (MDS) assessment dated 7/30/15 indicated Resident #104 required extensive assistance for eating. The MDS further indicate Resident#104 was cognitively impaired. Review of Resident #104 physician order dated 10/1/15 revealed, "occupational therapy evaluation only with placement of scoop dish (adaptive dining plate) for independent self-feeding" and "use scoop dish with all meals." Review of Resident #104 occupational therapy (OT) evaluation dated 10/1/15 indicated Resident #104 had difficulty feeding himself. The	F 369	followed timely. o When therapy records new recommendations for adaptive equipment on physician order forms, they will train the nursing staff caring for the resident, the SDC, and the appropriate nurse manager, on the proper use of the required adaptive equipment. o A list of the residents, and their needs, who require adaptive equipment is generated by the dietary manager whenever orders are added or changed and this list is available to staff who assist with meals. o A new program, Dining Room Monitor, will be initiated. In this program leadership staff will rotate being present in the dining room for each meal. They will observe the meal service, looking for appropriate use of adaptive equipment. o The Therapy Department, Dietary, Registered Dietitian, and Nurse Leadership will be educated on the newly defined system for communicating the need for, and implementing use of, adaptive equipment. o Nursing staff will be educated on the correct use of adaptive equipment and the location of the list which details which residents need which equipment. o Leadership staff will be educated on the Dining Room Monitor program. How will we monitor for improvement: o Random audits of 20% of the residents with orders for adaptive equipment will be conducted each week for 4 weeks, and then monthly for 3 months. o The results of these weekly and	

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

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CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 369	Continued From page 24 evaluation stated a scoop dish was recommended for all meals. Review of Resident #104's care plan updated 10/28/15 indicated a "problem" of being unable to perform any of his own care, dressing, bathing, and toileting without extensive assistance of staff. Due to cognitive loss Resident #104 was unable to follow instructions consistently. The goal stated Resident #104 would be able to maintain his ability to feed himself. The approaches did not include the use of adaptive equipment. Observation on 11/2/15 at 11:57 am revealed Resident #104 to be seated in front of a scoop dish. The scoop dish was observed to be turned backwards with the scoop side of the dish facing the resident. The scoop dish contained broccoli, mash potatoes and a bowl of soup. The bowl of soup was observed to be in the middle of the scoop dish. Resident #104 was observed eating the food around the bowl located in the center of the scoop dish. The resident was being provided assistance by the Assistant Director of Nursing (ADON). Observation on 11/4/15 at 8:27 am revealed Resident #104 to be assisted with dining by nursing assistant (NA) #6. NA#6 was observed to have Resident #104's meal tray directly in front of her on a bedside table. Resident #104 was observed to be to the left of staff. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the staff Interview on 11/4/15 at 8:27 am with NA#6 revealed Resident #104 was able to independently feed himself. The dietary department kept staff abreast through monthly meetings in which adaptive equipment and dietary concerns were discussed. NA#6 indicated the dietary department instructed her on how the adaptive equipment was used.	F 369	monthly audits will be presented to the Quality Management Team with QAPI at their monthly meeting for the next 3 months and the QMT with QAPI will modify the plan if the audits show unfavorable trends or continued non-compliance.	

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

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CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 369	Continued From page 25 Observation on 11/4/15 at 11:41 am revealed Resident #104 being assisted with dining by the ADON. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the resident. Resident was observed to be holding a piece of cake in his right hand and a dinner roll with his left hand. Observation on 11/4/15 at 5:00 pm revealed Resident #104 being assisted with dining by the ADON. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the resident. During an observation of Resident #104 on 11/4/15 at 5:07 pm and interview with the therapy director revealed Resident #104s scoop dish was not being used appropriately. The scoop portion of the dish should be facing away from the resident. Interview with the ADON on 11/5/15 at 8:02 am revealed she was not trained on the use of the scoop dish. She was unaware of which direction the scoop dish was to be placed. Interview with the Administrator on 11/5/15 at 8:20 am stated his expectation that recommendations for adaptive equipment be followed. He further indicated that his expectation was that adaptive equipment be used properly. Staff were to look at resident meal cards to ensure adaptive equipment needs were met. Staff were expected to communicate resident's needs or difficulty with recommended equipment to ensure therapy could put interventions into place.	F 369		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		12/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 26 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean and air dry 3 of 15 pans stored for use; maintain and clean 1 of 1 fan in operation in the kitchen area and maintain a temperature of 41 degrees Fahrenheit (F) or below in 1 of 3 nourishment refrigerators. Findings included: 1. On 11/04/2015 at 9:41 AM three pans were observed on the storage rack that had food particles and moisture both on the interior surfaces and the bottom of the pans. The other 12 pans were clean and dry. The Dietary Manager was present at the time the pans were viewed. He immediately set aside the pans to be rewashed. During an interview on 11/05/2015 at 10:08 am the Dietary Manager stated that the pans should have been properly cleaned and air-dried. He stated that he removed the excess pans after the observation 11/04/2015 to allow for more drying room and that the drying rack would be extended. He stated that he expects the pans to be clean and dry when stored. 2. On 11/04/2015 at 9:41 AM a fan located in the dishwashing area on the clean dishes side was observed blowing toward the dishwasher and drying racks. Lint had coated the wire covering of the fan with one string of lint dangling off the bottom right side of the fan covering. The Dietary Manager was present for the observation. The	F 371	F 371 For the resident cited: oNo resident cited. For other residents at risk: o System changes affect all residents. System changes: o Two new drying racks were purchased so there would be enough space to air dry all pans. o The floor fan was removed from use, permanently. o The supplement refrigerator located in the medication room at station 1 had become unplugged, causing the temperature within the unit to rise. The refrigerator was plugged back into the wall outlet. o All supplement refrigerators will checked each shift by nursing staff and any refrigerators that are not within acceptable range will be put out of commission until they are repaired. o Dietary staff will be trained on cleaning and drying of pans. o Nursing will be trained on monitoring / recording refrigerators temps for	

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F 371	Continued From page 27 Dietary Manager shared a job description for a dietary aide in which the fan cleaning was outlined to be once a week on Saturday and/or Sunday. The dietary manager was interviewed 11/05/2015 at 10:08 am. When asked how long it had been since the fan was cleaned he replied, "Obviously more than a week." 3. On 11/05/2015 at 3:31 pm the refrigerator for nutritional supplements located in the medication room for 100-300 halls was found to be unplugged. The temperature was observed to be 68 degrees F. The shelves and the items inside felt to the touch to be at room temperature. The refrigerator contained 10 nutritional shakes and 4 supplemental puddings. LPN #1 was present for the observation. The ADON was notified and interviewed immediately following the observation. When she was told that the supplement refrigerator had been unplugged, her response was, " Again? " She immediately went into the medication room plugged in the refrigerator and told staff to throw out the supplements that were not shelf stable. Registered Dietician #1 was on the floor at the time of the observation. She stated that the only items in the refrigerator that were not shelf stable were the Mighty Shakes. She further stated that the other items were only refrigerated for taste. A review of the temperature log labeled as the nutritional supplement refrigerator for the medication room indicated that the temperature was noted to be at 60 degrees F on 11/5/2015 at 1:00 AM. There was no notation to indicate that staff had attempted to correct the temperature at that time.	F 371	refrigerators located in the medication room, and on what to do if a refrigerator temp is outside of acceptable temps. The nursing staff will also trained on which outlets to avoid when charging medication carts, lifts, laptops. How will we monitor for improvement: o An audit will be conducted 5 times a week for 4 weeks, and then once per month for 3 months, of all pans after clean-up of meals, to ensure the pans have been completely cleaned and air dried before being stored. o Random review of the temperature logs of the supplement refrigerators located in the medication rooms will be conducted 5 times per week for 4 weeks, and then once per month for 3 months. o The audits of the pans and the daily temperature logs of the supplement refrigerators will be reviewed by the Quality Management Team with QAPI each month for the next 3 months and the QMT with QAPI will modified the plan if the audits of pan cleanliness / air dried, and supplement refrigerators show unfavorable trends and / or continued non-compliance.	
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		12/8/15

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

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F 520	Continued From page 28 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 10/09/2014 in order to achieve and sustain compliance. The facility had a deficiency on failure to prevent accidents (F323) from the recertification survey of 10/09/2014 and, again on the current recertification survey. The facility also had a deficiency on failure to develop	F 520	F 520 For the resident cited: o No specific resident cited. For other residents at risk: o All residents are affected by the system changes below.	

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F 520	Continued From page 29 comprehensive care plans (F279) on the recertification survey of 10/09/2014 and, again on the current recertification survey. The facility had a deficiency on failure to update comprehensive care plans (F280) on the recertification survey of 10/09/2014 and the current recertification Survey. The Immediate Jeopardy started on 7/29/15 at F323 when Resident #117 sustained a cervical vertebrae fracture and a dislocated shoulder as a result of a fall from an unsafe transfer. The Immediate Jeopardy was removed on 11/6/15 at 1:45 am when the facility provided a credible allegation of compliance. The facility will remain out of compliance at tag F323 at a scope and severity of G (actual harm that is not immediate Jeopardy) based on example 2 of tag F323. The findings included: 1.This tag is cross referenced to F 323: Based on observation, record review and staff interview the facility failed to have two persons perform transfers for 1 of 4 sampled residents (Resident #117) and failed to prevent spillage of hot liquids to prevent burns for 1 of 1 sampled residents (Resident #117). The administrator was notified of Immediate Jeopardy on 11/5/15 at 1:49pm. The administrator presented the following credible allegation of compliance: 1. Quality Management and Quality Assurance and Performance Improvement Team will be re-educated on 11/6/15 by the director of operations to ensure they function according to facility practice and is prompt at identifying trends, investigating issues, and initiating/revisiting plans of actions, and/or PIPs. The team includes: a. Administrator b. Director of nursing c. Medical Director	F 520	System changes: o The Quality Management (QM) with QAPI Team will be re-educated to ensure they function according to facility practice and re prompt at identifying unfavorable variances and trends, investigating issues, and initiating / revising plans of actions, PIPs and PoCs. The team includes: a. Administrator b. Director of Nursing c. Medical Director d. Assistant Director of Nursing e. Quality Manager / Staff Development f. Wound Nurse (removed from QM with QAPI Team on 11.18.15 g. Activity Director h. Therapy Director i. Maintenance Director (removed from QM with QAPI Team on 11.18.15) j. Social Work (vacant position) k. Dietary Manager o The training for the QM with QAPI Team will be conducted using the "Orientation for the Quality Manager" checklist, plus additional information on these items a. Policies related to Quality Management and QAPI. b. Which indicators to track and trend and how to read the charts and graphs. c. How to determine if an action plan is needed due to unfavorable trends, exceeded thresholds. d. How to conduct investigations into incidents / events. e. How to document investigations. f. How to track incidents per facility and per resident.	

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

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CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 520	Continued From page 30 d. Assistant Director of Nursing e. Quality Manager/Staff Development f. Wound Nurse g. Activities director h. Therapy Director i. Maintenance j. Social Work k. Dietary Manager 2. The training for the QM Team will be conducted, on 11/6/15 by the director of operations, using the "Orientation for the Quality Manager" checklist, and additional information on these items a. Policies related to the quality Management and QAPI Program b. Which indicators to track and trend and how to read the charts and graphs c. How to determine if an action plan is needed due to unfavorable trends exceeded thresholds d. How to conduct investigations into incidents/events e. How to document investigations f. How to track incidents per facility and per resident g. How to hold their QM and QAPI meetings each month using the agenda that requires they review all action plans, indicators, incident trends, etc. h. How to initiate and follow through on action plans, and or PIP. 3. Daily stand up meetings will be held with review of the incident reports. Trends and interventions will be discussed with changes in interventions as appropriate. Validation of the credible allegation of compliance was conducted on 11/6/15 at 1:30 PM. Review of the in-service material and interviews with	F 520	g. How to hold their Quality Management with QAPI Team meetings each month using the agenda that requires they review all action plans, indicators, incident trends etc. h. How to initiate and follow through on action plans, PIPs, and PoCs to ensure the plans are effective. o To monitor for repeat deficiencies related to supervision to prevent accident / hazards, incident reports are reviewed by the Quality Management with QAPI team members during the IDT morning meeting, 5 days a week, every week, for 12 months. Trends for random and systemic errors for individual residents, and / or for the facility in general, will be identified, root cause analysis will be conducted, and action plans for random errors will be developed and implemented to correct the potential for accidents / hazards. A full PIP, using FOCUS PDCA which includes root cause analysis, will be undertaken if the concern is a system concern rather than a random error. o To eliminate repeat deficiencies related to producing comprehensive care plans, (F 279), each time a comprehensive assessment is completed, the care plan will be reviewed by the ITD and Director of Nursing to ensure all care area triggers were considered for the need for a care plan. This will continue for 12 months. o To eliminate repeat deficiencies related to updating care plans, our morning clinical meeting agenda was modified to include the item, update care plan and SmartChart as indicated. The staff will	

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F 520	Continued From page 31 administration were conducted. The inservice information was reviewed which included use of the total lift, safety precautions to take, ensure the clip "clicks" and where to find the information regarding how many staff required to transfer a resident. Direct care staff and nurses were interviewed concerning the inservice information. Interviews were conducted with administrative staff regarding the plan for education for staff not currently working. A plan was in place for the weekend to ensure staff would receive inservice training before working. Observation of direct care staff using a mechanical lift for a total care resident revealed no resident safety concern during transfer. 2. This tag is cross referenced to F 279: Based on record review and staff interview the facility failed to develop a care plan for the use of an antipsychotic medication for one of one sampled residents on antipsychotic medications. (Resident # 41) 3.This tag is cross referenced to F 280: Based on observations, record review and staff interview, the facility failed to update the care plan of 1 of 1 resident with current interventions due to the resident's refusals of a splinting device. (Resident #92). The facility failed to update the care plan for interventions of adaptive eating equipment for two of three residents (Residents #49 and 104). An interview was conducted on 11/05/2015 3:36 PM with the facility's Staff Development Coordinator (SDC) which revealed that the SDC was responsible for being the contact person for the facility's Quality Assessment and Assurance (QAA) committee. She did note that she was new to the position and was not aware of the previous citations that the facility had received or the need	F 520	update the care plan and SmartChart, daily, as physician orders and or dietary / therapy recommendations indicate changes in therapy, medications, treatments, adaptive equipment etc. How we will monitor for improvement: o Incidents will be tracked monthly for 12 months to identify unfavorable trends and system errors / concerns. The Quality Management (QM) with QAPI Team will review the tracking reports monthly and the plan will be modified if the QM with QAPI team identifies system concerns, and / or if unfavorable trends or continued non-compliance is identified. o Random audits of the medical records of 10% of all skilled residents will be conducted each month for 3 months, and quarterly for 9 months, to ensure the residents□ current condition, and the care being given, is reflected in the care plan. These audits will be presented to the Quality Management with QAPI Team each month at their monthly meeting and the QM with QAPI team will modify the plan if unfavorable trends or continued non-compliance is identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 32 for continued follow up to prevent future citations in the same previously cited areas. The SDC stated that the QAA committee met generally one time a month, but definitely met quarterly. Committee members included the Medical director, facility administrator, registered dietician, the activity coordinator, social worker, the DON and SDC as well as other (ancillary staff) staff members as able to schedule attendance. The SDC did reveal log books, in services and follow up on previous plans of correction follow up, and also a log book including meeting minutes for current QAA issues being addressed which included weight loss, wound management, and investigative procedures for root causes and analysis of the previously mentioned areas.	F 520		