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	345298	A. BUILDING _____ B. WING _____	08/25/2011

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		9/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/16/2011

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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This REQUIREMENT is not met as evidenced by:
Based on staff interview and review of facility records, the facility failed to submit a twenty-four hour report and complete five day report to the state agency for one (1) of five (5) sampled residents who reported an allegation of neglect and rough handling by staff. (Resident # 83)

The findings are:

Resident # 83 was admitted to the facility on 10/15/2010 with the diagnoses which include: Depression, Debilitation Secondary to MS (Multiple Sclerosis) with recent exacerbation, Chronic Constipation and Chronic Fatigue. The resident ' s admission ' s Minimum Data Set (MDS) assessment dated 10/15/2010, documented the resident had no short or long term memory problems, needed extensive assistance with dressing, eating, toilet use and personal hygiene. Review of the Care Area Assessment (CAA) dated 10/15/2010 documented the resident " currently requiring extensive assistance to total care with all aspects of ADLs (Activities of Daily Living). She does require a one to two person extensive assistance with bed mobility. She does require a Hoyer lift with a two person assist with all transfers. She is non ambulatory and does use a wheel chair as her primary mode of locomotion. She is dependent upon staff for all chair locomotion. "

Review of the Complaint/ Grievance report dated 7/7/2011 which was filed by Resident # 83 documented under findings of investigation " NA (Nurse Assistant) #1 today was rough with resident while getting her out of bed, she hit her head. NA#2 (another Nurse Assistant) won ' t

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open the blinds, give her a cup of coffee, feed her, or take her to the bathroom. NA#1 will also not take her to the bathroom; she has told her before that she has to go in her brief. "

During the initial tour of the facility on 8/23/2011 at 11:00 AM, Resident # 83 reported the staff at the facility were rude to her and refused to provide requested care which included assistance to use the bathroom, assisting with water to drink and assisting with feeding. The resident added she had reported her concerns to multiple staff which included the Administrator, but nothing was done. Resident # 83 reported the most recent refusal of care occurred when she requested to use the bathroom while in the shower room and NA #1 said to her that she had to go in her brief. The resident further reported that she felt that the NAs at the facility did not want to help her with her needs. The resident was able to identify by names the staff members who refused to provide requested care.

During an interview with the Administrator on 8/24/2011 at 10:00 AM, he stated that the resident had reported to him about the staff refusing to provide requested care. The administrator also reported that he did not feel that the resident had been neglected or handled roughly after speaking to the resident. The Administrator further reported he did not investigate the resident ' s allegations per the facility ' s abuse policy because he felt that the allegations did not warrant a neglect investigation. The administrator also stated the staff member that was mentioned in the allegation was moved to other assignments at the facility. He (Administrator) further stated the staff members who were named in the allegation by Resident #

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83 were not suspended but one of them was given a verbal reprimand.

During an interview with ADON (Assistant Director of Nursing) on 8/24/2011 at 11: 00 AM, she reported that she was assigned to investigate the allegation of staff refusing to provide requested care to Resident # 83 but she did not see the allegation as neglect. Afterwards, the ADON was asked to review the facility ' s abuse policy at the time of the interview. The ADON stated she did not follow the facility ' s abuse/neglect policy because she did not suspend the staff members who were accused of not providing care to Resident # 83. ADON also added she did not complete the 24 hours and 5 days report as indicated in the facility ' s abuse/ neglect policy

On 8/24/2011 at 2:00 PM, an interview was held with Nursing Assistant (NA) #3. NA # 3 cared for Resident # 83on the 7AM to 3 PM shift. She identified Resident #83 as alert, oriented and reliable. The NA # 3 reported that the resident had good and bad days. The NA #3 reported she would leave the room if she had a feeling that the resident was having a bad day. The NA #3 also reported that Resident # 83 required extensive assistance with all the ADLs.

An interview was held with the DON on 8/25/2011 at 9:00 AM. She stated that refusing to help a resident transfer to the bedside commode, not providing incontinent care or failing to turn and position a resident would be considered neglect. The DON stated her expectation would be for the staff member receiving those allegations to report it immediately to her or to the Administrator for investigation. The DON also reported she will

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F 225	Continued From page 4 make sure that next time she will follow the abuse policy by suspending the staff member who has been accused of neglect, and complete 24 hours and 5 days report. The DON further stated she will also make sure the investigation is sent to the state agency after the completion of the investigation.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, record review, and facility policy review the facility failed to implement their policies and procedures to identify, protect, investigate, and report allegations of neglect and rough handling of resident by staff for one (1)of five (5)sampled residents. (Resident # 83) Findings include: Facility policy titled " ABUSE PREVENTION PROGRAM GUIDELINES " dated 5/12/2011 indicated staff would be trained about the abuse policies during orientation and throughout periodic in-service sessions. Training would include making staff aware that investigations would be conducted on any alleged incident of neglect, and alleged incidents would be reported to state agencies. The facility policy also documented that abuse prevention program includes:	F 226		9/22/11

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1- Investigate of all incidents, complaints and allegation;
2- Protect residents during investigation,
3- Report and respond to the outcome of investigation.

Resident # 83 was admitted to the facility on 10/15/2010 with the diagnoses which include: Depression, Debilitation Secondary to MS (Multiple Sclerosis) with recent exacerbation, Chronic Constipation and Chronic Fatigue. The resident ' s admission ' s Minimum Data Set (MDS) assessment dated 10/15/2010, documented the resident had no short or long term memory problems, needed extensive assistance with dressing, eating, toilet use and personal hygiene. Review of the Care Area Assessment (CAA) dated 10/15/2010 documented the resident " currently requiring extensive assistance to total care with all aspects of ADLs (Activities of Daily Living). She does require a one to two person extensive assistance with bed mobility. She does require a Hoyer lift with a two person assist with all transfers. She is non ambulatory and does use a wheel chair as her primary mode of locomotion. She is dependent upon staff for all chair locomotion. "

Review of the Complaint/ Grievance report dated 7/7/2011 which was filed by Resident # 83 documented under findings of investigation " NA (Nurse Assistant) #1 today was rough with resident while getting her out of bed, she hit her head. NA#2 (another Nurse Assistant) won ' t open the blinds, give her a cup of coffee, feed her, or take her to the bathroom. NA#1 will also not take her to the bathroom; she has told her before that she has to go in her brief. "

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During the initial tour of the facility on 8/23/2011 at 11:00 AM, Resident # 83 reported the staff at the facility were rude to her and refused to provide requested care which included assistance to use the bathroom, assisting with water to drink and assisting with feeding. The resident added she had reported her concerns to multiple staff which included the Administrator, but nothing was done. Resident # 83 reported the most recent refusal of care occurred when she requested to use the bathroom while in the shower room and NA #1 said to her that she had to go in her brief. The resident further reported that she felt that the NAs at the facility did not want to help her with her needs. The resident was able to identify by names the staff members who refused to provide requested care.

During an interview with the Administrator on 8/24/2011 at 10:00 AM, he stated that the resident had reported to him about the staff refusing to provide requested care. The administrator also reported that he did not feel that the resident had been neglected or handled roughly after speaking to the resident. The Administrator further reported he did not investigate the resident's allegations per the facility ' s abuse policy because he felt that the allegations did not warrant a neglect investigation. The administrator also stated the staff member that was mentioned in the allegation was moved to other assignments at the facility. He (Administrator) further stated the staff members who were named in the allegation by Resident # 83 were not suspended but one of them was given a verbal reprimand.

During an interview with ADON (Assistant Director of Nursing) on 8/24/2011 at 11: 00 AM,

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she reported that she was assigned to investigate the allegation of staff refusing to provide requested care to Resident #83 but she did not see the allegation as neglect. Afterwards, the ADON was asked to review the facility's abuse policy at the time of the interview. The ADON stated she did not follow the facility's abuse/neglect policy because she did not suspend the staff members who were accused of not providing care to Resident #83. ADON also added she did not complete the 24 hours and 5 days report as indicated in the facility's abuse/ neglect policy.

On 8/24/2011 at 2:00 PM, an interview was held with Nursing Assistant (NA) #3. NA #3 cared for Resident #83on the 7AM to 3 PM shift. She identified Resident #83 as alert, oriented and reliable. The NA #3 reported that the resident had good and bad days. The NA #3 reported she would leave the room if she had a feeling that the resident was having a bad day. The NA #3 also reported that Resident # 83 required extensive assistance with all the ADLs.

An interview was held with the DON on 8/25/2011 at 9:00 AM. She stated that refusing to help a resident transfer to the bedside commode, not providing incontinent care or failing to turn and position a resident would be considered neglect. The DON stated her expectation would be for the staff member receiving those allegations to report it immediately to her or to the Administrator for investigation. The DON also reported she will make sure that next time she will follow the abuse policy by suspending the staff member who has been accused of neglect, and complete 24 hours and 5 days report. The DON further stated she will also make sure the investigation is sent to the

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F 226	Continued From page 8 state agency after the completion of the investigation.	F 226		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to keep fingernails trimmed and clean for 1 of 2 dependent sampled residents (Resident #3 and resident # 40) and failed to provide shaving for 1 of 2 dependent sampled residents (Resident #40). Findings include: 1. Resident #3 was readmitted to the facility on 6/19/11 with cumulative diagnoses of altered mental status resolved, falls resolved, right middle lobe pneumonia, and chronic obstructive pulmonary disease. The resident's most recent Change of status Minimum Data Set Assessment (MDS) dated 6/22/11 indicated the resident had no memory problems and was independent for cognitive skills for daily decision making. The Minimum Data Set assessment indicated the resident had no behavior present, had limitation of both lower extremities and required limited to extensive	F 312		9/22/11

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assistance with dressing, toilet use and personal hygiene.

On 8/23/11, Resident #3 was identified by the facility licensed staff as being alert and oriented and identified as requiring extensive assistance with Activities of Daily Living.

On 8/23/11 at 9:55 AM, the resident was observed sitting in his room with visible facial hair growth and with fingernails that curved over his finger tips approximate 3/4 inch long and with black matter underneath all nails in both hands.

Interview was held with the resident on 8/23/11 at 10:00 AM. The resident stated he had not been shaved for several days and he expressed a desire to be shaved before lunch and to also have his fingernails trimmed. The resident stated that he had requested to be shaved and to have nail care several times, but the staff keep saying to him that they were busy or that they were going to do it later but they did not do it.

Interview was held with the NA#1 at 11:30 AM on 8/23/11. The Na stated that the resident had been given morning care by the previous shift. NA#1 indicated she was going to shave the resident later. The NA added that she responsible for shaving residents assigned to her that had noticeable facial hair growth.

On 8/23/11 at 2:00 PM, the resident was observed sitting outside smoking and then in his room at 3:30 PM. The resident had noticeable facial hair growth and had nails approximately ¾ inch long curving over the finger tips in both hands. All fingernails had black matter underneath them. The resident stated he had not

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been bathed, shaved or offered nail care. The resident expressed a desire to be shaved and to also have his nails trimmed. The resident stated that staff does not offered to shave him or to do his fingernails. The resident stated that he tries to do as much as he can for himself but he is not able to shave self or to trimmed his nails

On 8/24/11 at 11:30 AM, the resident was observed in his room reading. The resident had noticeable facial hair growth and had long fingernails that curved down his finger tips with black matter under all nails. The resident stated that he had been assisted with bathing in the morning but that he was not offered to be shaved or to have his nails trimmed.

On 8/24/11 at 12:45 PM an interview was held with NA #1. The NA stated Resident #3 received his bath on 8/24/11 at approximately 9:30 AM. The NA stated that morning care should include assistance with bathing, oral care, hair care, nail care and shaving if needed. The NA stated that she had offered to shave the resident but he had refused. The NA#1 indicated he had reported the refusal to the nurse #4. She did not comment if she had trimmed or clean the resident nails.

During interview at 2:15 PM on 8/24/11, the resident stated that he had not refused to be shaved or to have his nail trimmed and added that no one had offered to shave him or to do his nails.

During interview at 2:00 PM, on 8/24/11, the charge nurse stated that her expectations of the

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staff would be that the direct care staff provides assistance with grooming, shaving, nail care, personal hygiene and all care needs for all residents under their care.

On 8/24/11 at 2:45 PM an interview was held with Nurse #4. Nurse #4 worked with Resident #3 on the 7 to 3 shift for the last 2 days. Nurse #4 stated morning care included a full bath, nail care, hair care, oral care and shaving if needed. Nails should be cleaned with each bath. NA's were allowed to trim the nails of a resident if the resident was not a diabetic. If the resident had a diagnosis of diabetes, then the NA is responsible to report to the nurse when nails needed trimming. She stated Resident #3 was alert, oriented and reliable and was dependent on staff for ADL care needs. Nurse #4 further stated that she monitored resident ' s care needs during daily assessment, by observations during med-pass and by talking with residents and family members.

An interview was held with the Director of Nursing (DON) on 8/24/11 at 3:00 PM. She stated that the expectations would be that the direct care staff provides assistance with grooming, shaving, nail care, personal hygiene and all care needs for all residents under their care.

2. Resident #40 cumulative diagnoses included: Atrial fibrillation, ventricular tachycardia, cardio-vascular accident, cardiovascular arterial disease and diabetes mellitus.

The most recent annual Minimum Data Set assessment (MDS) dated 5/27/11 indicated the

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resident memory was okay and he was independent for cognitive skills for daily decision making. The MDS for activities of daily living indicated the resident required extensive assistance with dressing, toilet use and personal hygiene.

The Care plan last updated on 6/17/11 indicated the resident requires extensive assistance with activities of daily living (ADL).

The Care Plan Interventions included; " Staff to provide assistance and encourage the resident to participate with bathing, dressing and personal hygiene. He currently requires extensive assistance. "

During the initial tour of the facility on 8/23/11 at 8:30 AM, Resident #40 was observed with approximate ¼ inch long jagged fingernails and with black matter underneath all fingernails in both hands.

On 8/23/11, Resident #40 was identified by the facility licensed staff as being alert and oriented and identified as requiring extensive assistance with activities of daily living and as being pleasant, cooperative and without behaviors.

An observation was made on 8/23/11 at 11:00 AM with the resident having long and jagged fingernails in both hands and with black matter underneath all nails. Resident #40 stated he had not received a bath and he had not received nail care for a while. The resident did not recall the last time his fingernails had been cleaned or trimmed.

Interview was held with the NA#1 at 11:30 AM on

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8/23/11. The Na stated she was going to provide morning care to the resident later in her shift.

At 4:00 PM on 8/23/11, Resident #40 stated he had received his bath after 1:00 PM. He stated he had not been offered to trim or cleaned his fingernails. The fingernails remained long, jagged and with black matter underneath all nails in both right and left hands.

On 8/24/11 at 9:00 AM the resident was again observed with approximate ¼ inch long, jagged fingernails with black matter underneath all fingernails in both right and left hands.

An interview was held with NA#1 at 11:45 AM on 8/24/11. The NA stated that she had bathed and cleaned the resident ' s fingernails and had informed the nurse that the resident needed his nails trimmed.

During interview with the Charge Nurse at 2:00 PM, on 8/24/11, the charge nurse stated that her expectations of the staff would be that the direct care staff provides assistance with grooming, nail care, personal hygiene and all care needs for all residents under their care.

On 8/24/11 at 2:45 PM an interview was held with Nurse #4. Nurse #4 worked with Resident #40 on the 7 to 3 shift for the last 2 days. Nurse #4 stated morning care included a full bath, nail care, hair care, oral care and shaving if needed. Nails should be cleaned with each bath. NA's were allowed to trim the nails of a resident if the resident was not a diabetic. If the resident had a diagnosis of diabetes, then the NA is responsible

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	345298	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL STREET BURGAW, NC 28425

(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 312	Continued From page 14 to report to the nurse when nails needed trimming. She stated Resident #40 was diabetic, was alert, oriented and reliable and was dependent on staff for ADL care needs. Nurse #4 further stated that she monitored resident ' s care needs during her daily shift assessment, by observations of residents during med-pass and by talking with residents and family members. The nurse stated that NA#1 had not informed her that the resident #40 needed to have his fingernail trimmed and did not comment if she had assessed the resident on her shift for nail care needs. On 8/24/11 at 3:30 PM, the resident was observed lying in bed with long jagged fingernails that had black matter underneath all fingernails. An interview was held with the Director of Nursing (DON) on 8/24/11 at 3:00 PM. She stated that her expectations would be for nurse assistants to provide nail care to residents during morning care as needed and as requested. The DON indicated the nurses were responsible for trimming fingernails for diabetic residents.	F 312		
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 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		9/22/11

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This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to label, cover and date food/liquid containers. The facility failed to store opened containers of liquids in a sanitary manner. The facility failed to keep the inside of the nourishment refrigerators and freezer portions sanitary and free from spills. This was evident in two of two resident nourishment refrigerators (100 hall and 400 hall). Findings included:

Observations of foods and beverages stored inside of nourishment refrigerators/freezer section and the unsanitary conditions revealed the following:
1. On 8/24/11 at 4:45 p.m., an observation of the nourishment refrigerator for the 100 hall revealed approximate 3 inch heavy accumulation of ice built up in the freezer section. The built- up of ice had splattered areas of brown stains. The floor of the inside of the refrigerator had dried brown and yellow substances that were sticky when touched. The drainage pan under the freezer section had a brownish colored dried substance on the surface and when touched was sticky. Strands of a dark brown substance that resembled hair were noted on the shelves inside the refrigerator. A bag of Colby cheese cubes was opened with 8 cubes remaining, but the bag was partially resealed. The section designated for the storage of eggs had small brown colored specks on the inside surface. There was a container of sour cream that was opened on 6/11/11 that belonged to a staff member. Before the contents of the container of sour cream could be examined Nurse #2 indicated the container was hers and threw the container in the trash. The gaskets

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around the door frame had an accumulation of brownish colored substances. Multiple tears were noted at the base of the door and the upper portion of the door. The inside plastic shelf of the door was cracked with a missing bar. There was an opened 16.9 ounce bottle of water that had been open, partially empty with no labeled name. The handle of the refrigerator door was broken and taped together.

Interview on 8/25/11 at 8:32 a.m. with (house keeper) HK#1 revealed she was usually assigned to the 100 unit and she was responsible for checking the refrigerators every day. HK#1 indicated the unit gets busy and she was not always able to have access to the refrigerator. HK#1 indicated "I don't check the refrigerator as often as I sure" and the last time she checked the status of the refrigerator was about 2 weeks ago (referring to 8/15/11).

Observations on 8/25/11 at 10:43 a.m. of the 100 unit refrigerator revealed the refrigerator portion was cleaned and items removed. The freezer remained with an accumulation of ice built -up. The handle of the refrigerator door was still broken and taped together.

On 8/24/11 at 5:05 p.m. , an observation of the nourishment
refrigerator for the 400 hall revealed dried brown, red, and yellow colored dried spills in the freezer portion. When touched the spills were sticky. A red straw that resembled being chewed was stuck to the freezer shelf. There were 4 (four) drinking cups ½ full with a frozen substance. One cup had a red colored substance, two with a yellow colored substance and one with a brown colored substance. One of drinking cups with the

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yellow frozen substance had a spoon stored in the frozen substance. There were no coverings on the cups and the cups were not labeled. A brown paper towel was wrapped around 2 (two) cartons of unopened frozen grape juice, which had adhered to the base of the freezer. An opened liter bottle labeled spring water contained an orange colored liquid that did not reflect the contents. There was an open 6 ounce apple juice container about ¼ full that was frozen with a straw in the carton. This straw was not covered was bend and resembled being previously used. An opened can of sprite soda which was ½ full had a brown paper towel inserted into the lid. There was a crumbling blueberry muffin partially wrapped in a brown paper towel in the refrigerator. There were dried cooked pasta and a black olive stuck to the shelf in the refrigerator. There were red spills on the shelves of the refrigerator. The refrigerator had 2 bins. One of the 2 bins had dried yellow colored spills. The other bin had numerous brown and black colored dried particles at the base. Interview with the Nurse#1 revealed Housekeeping was responsible for cleaning the refrigerator and nursing was responsible for storing, labeling and dating the content.

Interview with the housekeeper director (HK) on 8/24/11 at 5:20 p.m. revealed the facility did not have a written policy and procedure for the cleaning of the refrigerator. The HK director indicated his department was responsible for cleaning the refrigerator and the housekeeper assigned to the unit was responsible for checking the refrigerator for cleanliness each day and clean as necessary. HK director also indicated that the 11 p.m.-7 a.m. nursing staff were responsible for defrosting the refrigerator.

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Further interview revealed the 100 unit nourishment refrigerator had been defrosted " not to long ago " but was not able to recall exactly when the defrosting was done. During this interview the HK director indicated that the condition of the refrigerator " looked like it was not clean. "

Interview on 8/25/11 at 8:59 a.m. with HK#1 revealed she was aware that the nourishment refrigerators should be checked daily. HK director indicated she had not checked the refrigerator for weeks (unsure of exact date).

Observations on 8/25/11 at 11:30 a.m. of the 400 unit refrigerator revealed the refrigerator was cleaned and all unlabeled and uncover containers were remove. The gaskets around the base of the refrigerator door was still torn and detached.

On 8/24/11 at 5:30 p.m. the administrator and director of nurses were informed about the status of the refrigerators. Interview on 8/25/11 at 1:57 p.m. with the administrator and DON was held. The administrator indicated his expectation was to have staff inform him regarding the condition of the refrigerators and the refrigerator to be cleaned.