

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345279</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HUNTER HILLS NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>POST OFFICE BOX 8495 ROCKY MOUNT, NC 27804</b>	
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F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to ensure that staff applied a splint as ordered for 1 of 1 resident reviewed for splinting and range of motion services, Resident #118. Findings included: A review of the quarterly admission assessment dated 11/23/2015 revealed Resident #118 was re-admitted to the facility on 11/13/2015 with diagnoses including cardiovascular accident, hemiplegia, dementia, and aphasia. The same assessment indicated the resident was moderately cognitively impaired and that he was totally dependent upon staff to provide bathing, personal hygiene, eating, and dressing. The nursing care plan initiated on 12/05/2011 and last revised on 11/30/2015 included a goal and interventions to address Resident #118's risk for decreased range of motion related to his hemiplegia. The goal for this problem was that the resident would not have any further limitation of range of motion in the left upper extremity. Three of the interventions listed on the care plan to achieve this goal were as follows: 1) apply soft elbow splint to left elbow up to 6 hours per day, 7 days per week, 2) monitor skin integrity under the</p>	F 318	<p>Resident # 118 soft splint was applied as appropriate by CNA and documented in POC on 1/14/2016. Resident Care Guide for resident #118 was updated to include appropriate splinting on 1/13/2016 by the QI Nurse.</p> <p>100% audit of the residents receiving splinting program to include resident # 118 was completed to assure splints are applied &amp; documented appropriately in POC and splints on the Resident Care Guide as appropriate was completed by the DON and QI Nurse on 1/15/2016. 100% Certified Nursing Assistants to include NA #2 and RNA #1 will be in-serviced by 1/22/2016 re: applying splints and documenting in POC as appropriate by the DON. 100% Charge Nurses inserviced re: documentation in POC re: proper documentation for resident splint application as appropriate on 1/28/2016 by Assistant Director of Nursing. All newly hired Certified Nursing Assistants and Licensed Nurses to receive training re: applying splints and</p>	2/5/16

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

TITLE

(X6) DATE

Electronically Signed

02/04/2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 318	<p>Continued From page 1</p> <p>applied splint, and 3) if resident did not participate in splint/device program, document reason.</p> <p>A review of the Rehab Communications to Nursing dated 12/01/2015 indicated that a referral was made by the physical therapy department to the restorative nursing program, with restorative services to begin on 12/08/2015 upon discharge from the physical therapy program. The Rehab Communications to Nursing referral indicated the resident had a left elbow contracture and that treatment approaches were to include the application of a left elbow extension soft splint daily for 4 - 6 hours.</p> <p>The resident care guide posted in Resident #118 's room included a list of care directives to be provided for the resident. The resident care guide did not include a directive for the application of the left upper extremity splint. Printed on the lower right side of the resident care guide document was "12/01/2015, Page 1 of 1."</p> <p>A review of the current Restorative Caseload for the facility provided on 01/12/2015 revealed Resident #118 was not listed on the caseload for splint application.</p> <p>In an observation and an interview with Resident #118 on 1/12/2016 at 11:00 AM, he stated that the facility used to provide range of motion exercises to him on his arms and legs, and that he used to wear a splint on his left arm. The resident was not wearing a left elbow splint at the time of the interview.</p> <p>An observation of Resident #118 on 01/12/2016 at 3:00 PM revealed the resident was not wearing the left arm splint.</p>	F 318	<p>documentation in POC/PCC during orientation.</p> <p>The ADON, QI Nurse, Treatment Nurses, &amp; weekend Supervisor will audit resident splints by direct resident observation to include resident # 118, review of the resident care guide, and documentation in the electronic health record daily for 4 weeks, then weekly for 4 weeks, then monthly for 1 months utilizing a Splint Application and Documentation audit tool to ensure splints are being applied as appropriate. All identified areas of concern will be addressed during the audit by the ADON and weekend supervisor to include splint application and retraining as needed. The DON will initial and review the Splint Application and Documentation audit tool to ensure all identified areas of concern have been addressed and to identify any systemic areas of concern.</p> <p>Results of the QI Splint Application and Documentation Audit tool will be forwarded to the facility's Quality Improvement committee by the DON and/or ADON monthly for 3 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.</p>		

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F 318	<p>Continued From page 2</p> <p>During an interview on 01/13/2016 at 11:32 AM with the nursing assistant (NA #2) who was assigned to Resident #118 (NA #2), she explained she did not often work with Resident #118, and that she did not know anything about splints the resident was to wear. The nursing assistant stated she would need to check his care guide for splinting information.</p> <p>During an observation on 01/13/2016 at 11:50 AM, Resident #118 was not wearing a left arm splint.</p> <p>In an interview on 01/13/2016 at 3:48 PM with the physical therapy assistant (PTA), she stated Resident #118 had tolerated his splinting and range of motion exercises well during physical therapy services he received from 11/24/2015 through 12/07/2015. She explained that the resident made progress during therapy as evidenced by an increase in range of motion for his upper and lower extremities, including his left elbow. The PTA also stated the physical therapy department trained two restorative nursing assistants regarding the left elbow splint application upon referral to restorative nursing services.</p> <p>During an interview with the restorative nurse on 01/13/2016 at 4:00 PM, she stated that Resident #118 was receiving range of motion exercises and the application of a soft splint to his left elbow through the restorative nursing program. She added that the orders for restorative exercises and splinting were entered on the medication/treatment administration record so that the assigned hall nurse would check to ensure the splinting and range of motion exercises were complete.</p>	F 318			

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F 318	<p>Continued From page 3</p> <p>During the interview with the restorative nurse on 01/13/2016 at 4:00 PM, she reviewed the resident's medication/treatment administration records for December 2015 and January 2016 noted there were no entries for the application of a splint for his left arm.</p> <p>An interview was conducted with the restorative nursing assistant (RNA #1) on 01/13/2016 at 4:28 PM. RNA #1 stated she no longer needed to apply Resident #118's left arm splint because the regular nursing assistants on his hall were applying it.</p> <p>Resident #118 stated in an interview on 01/13/2016 at 4:40 PM that he had not had the splint applied on 01/12/2016 or on 01/13/2016. The resident was not wearing the splint at the time of the interview.</p> <p>In an interview with the Director of Nursing (DON) on 01/13/2015 at 4:58 PM, she reviewed Resident #118's care guide which was posted in his room and stated she was not sure why the left elbow splint or the range of motion exercises were not included on the care guide.</p> <p>The restorative nurse stated in an interview on 01/13/2016 at 5:10 PM that she must have forgotten to print off an updated resident care guide after the splint for the left elbow was added to the treatment plan for Resident #118.</p> <p>A review of the restorative nursing point of care documentation revealed that there was no entry to indicate the left elbow splint was applied on the following dates: 12/12/2015, 12/13/2015, 12/18/2015, 12/29/2015, 12/30/2015, or</p>	F 318			

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F 318	<p>Continued From page 4</p> <p>01/06/2016. In addition, the splint skin integrity checks were not documented as completed by the assigned nurse on 12/18/2015, 01/03/2016, 01/04/2016, 01/05/2016, 01/07/2016, 01/08/2016, 01/09/2016, or 01/11/2016.</p> <p>A review of Resident #118's medication administration record for January 2016 on 01/14/2016 at 9:30 AM revealed an entry was made for the following to begin on 01/14/2016: "CNA (certified nursing assistant) to apply elbow splint for up to 6 hours daily by 11:00 AM." The medication administration record was initialed as completed for 01/14/2016.</p> <p>On 01/14/2016 at 12:10 PM, the facility's regional vice president stated that the assigned nurse documented in the electronic medical record to indicate that skin checks for residents with splints were completed. He explained that this documentation was reflected in the point of care system. He explained that if the nurse did not complete the documentation for the skin integrity check, it would not ensure that the splint had been in place. In addition, he stated that splint application should not be included on the medication or treatment record because it should only be reflected electronically via the point of care system.</p> <p>During an interview with the DON and the Administrator on 01/14/2016 at 1:00 PM, the DON stated that historically, there had been a large number of residents on the restorative caseload. She added that the restorative nurse probably added the application of the left elbow splint to the medication administration record to help ensure that it was done.</p>	F 318			

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F 371 F 371 SS=E	Continued From page 5 483.35(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  This REQUIREMENT is not met as evidenced by: Based on observation, service representative interview, and staff interview the facility failed to monitor the dish machine temperature gauge which resulted in not meeting manufacturer's minimum temperature standards and failed to maintain sanitizing solutions at the strength recommended by the manufacturer. Findings included:  1. Observation of the dish machine began on 01/13/16 at 9:10 AM. Three staff members were involved in this dish machine process, but none of the employees were watching the dish machine temperature gauge.  Six racks of kitchenware were run through the dish machine on 01/13/16 between 9:18 AM and 9:30 AM. Wash and final rinse temperatures ranged from 108 to 111 degrees Fahrenheit. At this time the dietary manager (DM) and assistant dietary manager (ADM) stated they were unsure what the wash and final rinse temperatures should be since the dish machine was a low	F 371 F 371	The low temperature sanitation machine was serviced by Ecolab on 1/13/2016 to assure the temperature and sanitation solution dispenser is working properly. Hot water heater for dishwashing machine was replaced on 1/28/2016 by an outside contractor. Sanitation bucket rinse immediately changed and pH levels verified on 1/13/2016 to be within appropriate range by Dietary Manager.  100% inservicing was initiated on 1/13/2016 for the Cooks and Dietary Aides re: monitoring and documenting the dish machine temperatures and pH levels in the sanitation buckets for general cleaning utilizing a log sheet. Any issues identified to be immediately reported and dishwasher to be taken out of service was completed by the Dietary Manager on 1/28/2016.  Dietary Staff to include Dietary aides and	2/5/16	

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F 371	<p>Continued From page 6</p> <p>temperature model which had a sanitizing solution feeding into it. One of the dietary employees operating the dish machine reported she thought she recalled the service representative telling the staff the wash and rinse temperatures should be 140 degrees Fahrenheit or above.</p> <p>At 9:35 AM on 01/13/16 a strip was used to check the strength of the sanitizer feeding into the dish machine. The strip registered 100 parts per million hypochlorite.</p> <p>At 4:00 PM on 01/13/16 the dish machine service representative stated even though a sanitizing solution fed into the dish machine the manufacturer's recommendation for maximized sanitization was maintaining the wash and final rinse temperature at or above 120 degrees Fahrenheit. As a precaution the representative reported he was going to replace the temperature gauge on the dish machine. The representative commented strips used to check the strength of the dish machine sanitizing solution were supposed to register at least 50 parts per million hypochlorite.</p> <p>At 11:08 AM on 01/14/16 the DM stated in previous in-servicing the dietary staff was told they should watch the temperature gauge the entire time kitchenware was being run through the dish machine. She reported dietary staff were taught to stop the dish machine process if the gauge was not registering temperatures which were hot enough, let herself or the ADM know about the problem, allow time for water in the dish machine to reheat, rerun the kitchenware, and if temperatures still did not meet manufacturer recommendations, sanitizing of the kitchenware</p>	F 371	<p>Cooks will document the temperature of the dish machine and general cleaning sanitation solution pH on a log daily and notify the dietary manager of any concerns daily. The Dietary manager/ Dietary Assistant Manager will review the dish machine temperature log and general cleaning sanitation pH level log utilizing a Dish Machine/Sanitation QI Audit tool 5 times per week for 4 weeks, then weekly for 1 month to ensure the dish machine temperature gauge meets manufacture's minimum temperature standards and sanitizing solutions maintains at the strength recommended by the manufacture and to ensure proper notification was completed for any areas of concern. Retraining will be conducted with dietary staff for all identified areas of concern. The Administrator to review and initial the Dish Machine/Sanitation QI audit tool weekly for 3 months to identify any systematic areas of concern and to ensure all areas of concern were addressed.</p> <p>Results of the Dish Machine/Sanitation QI Audit tool will be forwarded to the facility Quality Improvement Committee by the Dietary manager monthly for 3 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.</p>		

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F 371	<p>Continued From page 7</p> <p>would be completed through the three-compartment sink process.</p> <p>At 11:12 AM on 01/14/16 a dietary employee stated she was educated to check the dish machine temperatures by viewing the gauge when she first arrived around 6:00 AM each morning and when she began and completed operation of the dish machine after meals. She reported at these times if the wash and rinse temperatures did not reach 140 degrees Fahrenheit she would notify her DM or ADM. She commented the DM or ADM usually called the maintenance manager or the service representative to inspect the dish machine and identify what was causing the problem.</p> <p>2. At 9:14 AM and 9:20 AM on 01/13/16 a dietary employee wiped down emptied meal carts using a cloth from a red bucket.</p> <p>At 9:22 AM on 01/13/16 the dietary employee stated the red bucket contained quaternary sanitizing solution obtained from the three-compartment sink dispensing system.</p> <p>At 9:32 AM on 01/13/16 a strip used to check the strength of the sanitizing solution in the red bucket at the dish machine registered 0 - 50 parts per million quaternary. At this time the dietary employee, who had been wiping down meal carts using the solution, stated she made up the sanitizer bucket around 6:00 AM that morning when she started work.</p> <p>At 4:00 PM on 01/13/16 the dish machine service representative stated he was going to change the metering tip, pick-up line, and diaphragm in the three-compartment sink sanitizer dispensing</p>	F 371			



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F 371	<p>Continued From page 8</p> <p>system as a precaution. He reported in order for a quarternary sanitizing solution to be effective it needed to register 150 - 200 parts per million quaternary when checked with a strip.</p> <p>At 11:08 AM on 01/14/16 the DM stated sanitizer buckets were supposed to be made up with fresh solution three times daily, and a strip was to be used to check the strength of the solution each time. She reported she thought the dietary employee using the ineffective quarternary sanitizing solution added more solution to the bucket after 6:00 AM, and forgot to check its strength with a strip. The DM commented it was important to effectively sanitize meal carts because they might be contaminated with germs after being out in resident care and commons areas.</p> <p>At 11:12 AM on 01/14/16 the dietary employee, who used the ineffective sanitizer, stated she thought the solution she used weakened from the time it was made up around 6:00 AM and the time it was used again around 9:15 AM. She reported she only used a strip to check the strength of the sanitizing solution when it was first made up. The employee commented she was educated that strips should register 200 parts per million quaternary in order for the sanitizing solution to be effective. According to the dietary employee, it was important to sanitize meal carts as they were emptied to kill possible germs and bacteria they may have picked up after leaving the kitchen.</p>	F 371			