

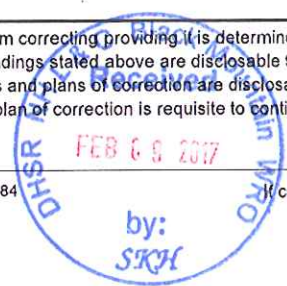
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2017
NAME OF PROVIDER OR SUPPLIER IREDELL MEMORIAL HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALE DRIVE STATESVILLE, NC 28677		
(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 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to code a resident's significant weight loss for 1 of 3 sampled residents reviewed for weight loss (Resident #135).</p>	F 278	<p>1. Corrective action for the resident affected by the alleged deficient practice: Resident # 135 MDS assessment was reopened and corrected on 1/20/17 reflecting the significant weight loss and transmitted to CMS on 1/24/17.</p> <p>2. All current residents at the time of survey who had a previous admission within the last 6 months were reviewed for any discrepancies in MDS section K. No issues were identified.</p> <p>3. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: The dietitian and MDS coordinator received re-education on Resident Assessment Instrument section K criteria and each demonstrated understanding by completing post test.</p> <p>4. Measures/Systemic changes put in place to assure the alleged deficient practice does not reoccur: Dietitian or designee is to meet weekly with Director of Nursing or designee and MDS Coordinator to discuss nutritional status to include but not be limited to the following residents: Any newly admitted residents; any residents readmitted who have had a previous stay within the last six months, and any current residents with a change in nutritional status including weight changes.</p> <p>5. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: Administrator will audit weight meeting minutes weekly X 3 months and review during QAPI.</p>	1/20/17 1/20/17 2/10/17 2/10/17 2/10/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rendy B. Smith, NHA TITLE: Administrator (X6) DATE: 02/08/2017

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 278	<p>Continued From page 1</p> <p>The findings included:</p> <p>Resident #135 was admitted to the facility on 11/30/16 and discharged home on 12/22/16 but was readmitted to the facility on 01/02/17. Her diagnoses included gastrointestinal hemorrhage, open heart surgery and edema.</p> <p>Review of her medical record revealed she weighed:</p> <table border="0"> <tr><td>11/30/16</td><td>219 pounds</td></tr> <tr><td>12/14/16</td><td>208 pounds</td></tr> <tr><td>12/15/16</td><td>208.6 pounds</td></tr> <tr><td>12/21/16</td><td>197 pounds</td></tr> <tr><td>12/28/16</td><td>197 pounds</td></tr> <tr><td>01/02/17</td><td>162 pounds</td></tr> <tr><td>01/04/17</td><td>162 pounds</td></tr> <tr><td>01/10/17</td><td>158.8 pounds</td></tr> </table> <p>Resident #135 lost approximately 27% of her body weight from 11/30/16 to 01/10/17.</p> <p>The Minimum Data Set (MDS) dated 01/09/17 specified the resident's cognition was intact and her weight was 163 pounds which was not a significant weight loss.</p> <p>On 01/18/17 at 11:09 AM Resident #135 was interviewed and state she had lost at least 50 pounds in a few months. She was wearing a gown and stated her gowns were loose and she was pleased with the weight loss.</p>	11/30/16	219 pounds	12/14/16	208 pounds	12/15/16	208.6 pounds	12/21/16	197 pounds	12/28/16	197 pounds	01/02/17	162 pounds	01/04/17	162 pounds	01/10/17	158.8 pounds	F 278			
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F 278	Continued From page 2	F 278			
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff and family interviews and record review the facility failed to record weight loss in the medical record and address weight loss for 1 of 3 sampled residents with significant weight loss (Resident #126).</p>	F 325	<p>1. Corrective action for the resident affected by the alleged deficient practice: Resident # 126 had been discharged at the time of survey.</p> <p>2. Weights were reviewed for all current residents to ensure any ordered weight had been entered into the EHR for dietitian review. No missed entries were identified. Completed on 1/20/17.</p> <p>3. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Weekly weights are to be obtained by a designated staff member and entered into the EHR.</p>	<p>1/20/17</p> <p>2/10/17</p>	

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F 325	<p>Continued From page 3</p> <p>The findings included:</p> <p>Resident #126 was admitted to the facility on 10/28/16 diagnosed with sepsis, pulmonary asbestosis, pulmonary fibrosis, acute respiratory failure, bilateral pneumonia, severe deconditioning and a stable hiatal hernia.</p> <p>On 10/31/16 Resident #126 weighed 130 pounds.</p> <p>Resident #126 had an "Adult Nutrition initial Assessment" dated 10/31/16 completed by the Registered dietitian (RD). The RD documented the resident was independent with eating, consuming 75-100% of estimated nutritional needs, had experienced unintended weight loss prior to admission, had a chronic illness but appeared to be eating better. The RD also documented the resident had "significant nutrition concerns" and weighed 130.5 pounds. The RD made recommendations to monitor the resident's intake, weight and appetite.</p> <p>The admission Minimum Data Set (MDS) dated 11/04/16 specified the resident's cognition was intact, required limited assistance with activities of daily living and weighed 130 pounds had no significant weight loss or gain and received a regular diet.</p> <p>Resident #126 did not have a Care Area Assessment (CAA) for nutritional status because the resident did not trigger for concern.</p> <p>An "Adult Nutrition Reassessment" was completed on 11/06/16 by the RD. The RD documented Resident #126's weight was 130 pounds and his intake had decreased to 30 -</p>	F 325	<p>4.Measures/Systemic changes put in place to assure the alleged deficient practice does not reoccur: Weekly weight meeting between DON or designee, MDS Coordinator, and dietitian or designee to review and discuss new admission weights and weekly weights to evaluate any changes in weight and modify plan of care and implement appropriate interventions as indicated.</p> <p>5. Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur: Weights will be audited weekly X 12 weeks, then monthly X 3 months by Director of Nursing or designee to insure ordered weights have been obtained and entered accurately into the electronic health record. Administrator will audit weight meeting minutes weekly X 3 months and review during QAPI.</p>	2/10/17	2/10/17

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F 325	<p>Continued From page 4</p> <p>100%. The RD recommended to encourage intake of meals, honor food preferences and monitor weight.</p> <p>On 11/10/16 Resident #126 was discharged home with his family and died on 11/15/16.</p> <p>On 01/18/17 at 9:10 AM a family member was interviewed on the telephone and reported the facility "did nothing" to address Resident #126's weight loss. The family member stated she was present when the resident was weighed and noted the weight loss. The family member explained she was present when the facility weighed Resident #126 and reported Resident #126 weighed 121 pounds just prior to discharge.</p> <p>Further review of Resident #126's medical record documented one weight of 130.5 pounds.</p> <p>On 01/19/17 at 10:40 AM the Director of Nursing (DON) was interviewed and explained residents were weighed weekly. She added the weights were documented on a weekly weight worksheet and given to her for review. The DON reported that she reviewed the weights before entering them into the electronic medical record. The DON added that she reviewed the weights for significant changes to determine if a resident needed to be reweighed. The DON stated any significant weight loss would be reported to the RD for review.</p> <p>The DON was able to provide weekly weight worksheets that included weights for Resident #126. The sheets documented Resident #126's weight was:</p> <table border="0"> <tr> <td>11/02/16</td> <td>121.4 pounds</td> </tr> <tr> <td>11/09/16</td> <td>125.3 pounds</td> </tr> </table>	11/02/16	121.4 pounds	11/09/16	125.3 pounds	F 325		
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F 325	Continued From page 5 The DON stated she was new in her role as of October 2016 and was on a leave of absence in November 2016 and the weights were not entered in Resident #126's medical record because of an oversight. The DON stated Resident #126 was working with speech therapy and felt the resident's decreased intake would improve with speech therapy services. Resident #126's physician was on medical leave and unable to be reached for an interview. On 01/19/17 at 11:09 AM the RD was interviewed and explained that she noted on 11/06/16 Resident #126's intake had decreased significantly but since there was no documented weight loss, she felt interventions were not necessary. The RD stated that if she had been notified of Resident #126's weight loss from 130 pounds to 121.4 pounds she would have reassessed the resident and made recommendations. The RD reported that she would review the medical record to look for weights in the electronic chart or be notified by the DON if a resident had weight loss. The RD stated she was unaware Resident #126 had a significant weight loss and was not made aware of the 121.4 pound or 125.3 weights for the resident.	F 325			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514	1. Corrective action for the resident affected by the alleged deficient practice: Resident # 126 had been discharged at the time of survey. 2. Weights were reviewed for all current residents to ensure any ordered weight had been entered into the EHR. No missed entries were identified.		

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F 514	<p>Continued From page 6 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document weights in a medical record for a resident with weight loss for 1 of 3 sampled residents (Resident #126).</p> <p>The findings included:</p> <p>Resident #126 was admitted to the facility on 10/28/16 diagnosed with sepsis, pulmonary asbestosis, pulmonary fibrosis, acute respiratory failure, bilateral pneumonia, severe deconditioning and a stable hiatal hernia.</p> <p>On 10/31/16 Resident #126 weighed 130.5 pounds.</p> <p>The admission Minimum Data Set (MDS) dated 11/04/16 specified the resident's cognition was intact, required limited assistance with activities of daily living and weighed 130 pounds had no significant weight loss or gain and received a regular diet.</p> <p>On 11/10/16 Resident #126 was discharged home with his family and died on 11/15/16.</p> <p>Further review of Resident #126's medical record</p>	F 514	<p>3. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Weekly weights are to be obtained by a designated staff member and entered into the EHR.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: Weights will be audited weekly X 12 weeks then monthly X 3 months by Director of Nursing or designee to insure ordered weights have been obtained and entered accurately into the electronic health record. Administrator will audit weight meeting minutes weekly X 3 months and review during QAPI.</p>	2/10/17	2/10/17

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F 514	<p>Continued From page 7</p> <p>documented one weight of 130.5 pounds.</p> <p>On 01/19/17 at 10:40 AM the Director of Nursing (DON) was interviewed and explained residents were weighed weekly. She added the weights were documented on a weekly weight sheet and given to her for review. The DON reported that she reviewed the weights before entering them into the electronic medical record. The DON added that she reviewed the weights before entering them into the electronic medical record to look for significant changes to determine if a resident needed to be reweighed.</p> <p>The DON provided weekly weight worksheets that included additional weights for Resident #126. The sheets documented Resident #126's weight was:</p> <p>11/02/16 121.4 pounds 11/09/16 125.3 pounds</p> <p>The DON stated she was new in her role as of October 2016 and was on a leave of absence in November 2016 and the weights were not entered in Resident #126's medical record because of an oversight.</p>	F 514			