

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/30/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTLAND LIVING &amp; REHAB AT THE MOSES H CONE MEM H</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1131 NORTH CHURCH STREET GREENSBORO, NC 27401</b>		
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F 309 SS=D	<p>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to change the left below the knee amputation surgical leg dressing for 1 of 3 sampled residents (Resident # 4). Findings Included: Resident #4 was admitted on 5-19-15 with diagnosis in part, right below the knee amputation his Minimum Data Set (MDS) dated 06-02-15, indicated he had intact long and short term memory. Review of the physician order dated 06-09-15 revealed " Cleanse right BKA (below the knee amputation) with n/s (normal saline) or wound cleanser qd (every day). Review of the Treatment Administration Record (TAR) dated 06-27-15 at 7:00 am, revealed the dressing change to the right below the knee amputation was not signed of as completed on 06-27-15. Review of the nursing note dated 06-27-15 at 12:05pm, revealed in part, " Resident came back from (named hospital) emergency department ... " During interview on 6-30-15 at 11:52am, the administrator indicated when the wound care</p>	F 309	<p>For the Resident Affected</p> <p>The facility will provide care to maintain each resident's highest practicable well being. The surgical leg dressing for resident #4 was assessed on 6/30/15 with improvement noted. Resident's #4's surgical dressing will be changed as ordered.</p> <p>For All Residents</p> <p>Licensed staff will be inserviced regarding licensed nurse responsibilities as it relates to dressing changes.</p> <p>System Changes</p> <p>DON or designee will review treatment administration records for all residents weekly. Any dressing changes recorded as not administered will be reviewed by the DON or designee for the reason the treatment order could not be carried out and follow-up with licensed staff as</p>	7/20/15	

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

TITLE

(X6) DATE

Electronically Signed

07/20/2015

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

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F 309	Continued From page 1 nurse had not completed the wound care, the next shift nurse was expected to do the dressing change and document. During interview 06-30-15 at 10:54am, charge nurse #1 indicated dressing changes were the responsibility of the nurse scheduled on that hall. Once a resident returned to the facility and had a dressing documented as not completed the nurse who received the resident was to do the dressing change. During a telephone interview on 6-30-15 at 3:03pm, nurse # 3 indicated the dressing was not completed during the day shift because Resident #4 was at the hospital for a procedure and returned about noon. He indicated the next shift nurse was responsible to change the dressings. During a telephone interview on 6-30-15 at 4:18pm, nurse #4 indicated she arrived for the second shift and the right below the knee amputation dressing was not redressed.	F 309	indicated. A QI audit tool will be utilized.  Monitors  QI audit tools will be submitted to the Monthly Quality Committee monthly for review to ensure ongoing compliance.		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.25(a)(3)  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 observation, record review and interview the facility failed to put on compression stockings for 1 of 3 sampled residents (Resident #3). Findings included:	F 312	The facility will provide ADL care for dependent residents.  For Residents Affected	7/20/15	

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F 312	Continued From page 2 Resident # 3 was admitted to the facility on 08-09-2014 and readmitted on 4-20-2015 with a diagnosis of multiple sclerosis. Review of the Minimum Data Set (MDS) dated 5-13-15, revealed Resident #3 was alert and oriented with intact long and short term memory. She required extensive assistance with bed mobility, dressing, eating and total assistance with personal hygiene. Resident #3 had inability to move both the upper and lower extremities. Review of the physician order dated 10-21-14, revealed " TED hose (compression stockings) on in the am off at bedtime. " Review of the Medication Administration Record (MAR) dated 6-3-15 revealed compression stockings were ordered on 6-3-15 and scheduled to be put on at 8:00am and removed at 8:00pm. During interview on 06-30-15 at 10:41am, assistant director of nursing indicated all nurses entered the physician orders into the computer. The new resident orders were entered into the computer by administrative nurses, which included the MDS nurses, the wound care nurse, the staff development coordinator and her herself. On the weekend it was the nurse supervisor entered the orders. Each administrative nurse had a scheduled day to put in the new patient orders. When the scheduled nurse was not available the director of nursing or assistant director of nursing assigned the administrative nurse to enter the orders. Orders were checked for accuracy each weekday morning by the administrative nursing team. The compression stockings were put on the Treatment Administration Record (TAR) and the kiosk Kardex. The information was also on the 24 hour report, and were discarded after 3 weeks. During interview on 6-30-15 at 11:12am, Resident #3 indicated her compression stockings were not	F 312	Resident #3 will have her compression stockings applied daily. Resident #3's Kardex was updated to indicate compression stockings are to be applied daily.  For all residents  DON or designee will conduct an audit of residents who have a physician's order to wear compression stockings. DON or designee will audit to ensure the use of compression stockings is on each resident's care plan, Kardex, and medication administration record. Licensed and CNA staff will be inserviced regarding the application and documentation of compression stockings.  System Changes  DON or designee will review new orders for compression stockings and ensure they are added to the resident's care plan, Kardex and medication administration record.  QI nurse or designee will conduct an audit weekly for four weeks, of the Kardex, care plan, and medication administration record of each resident who had orders for compression stockings. A QI tool will be utilized.  Administrative nurses and nurse supervisors will conduct an audit three times weekly for four weeks of resident care, to ensure residents have compression stockings applied as		

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F 312	<p>Continued From page 3</p> <p>put on her legs every day.</p> <p>During an interview on 6-30-15 at 11:16am, Aide # 1 indicated she had not put compression stockings on Resident # 3. She indicated she was not aware that Resident #3 had compression stockings. When asked how she would know Resident # 3 had compression stockings, she indicated the nurse would tell her and it would be on the activities of daily living (ADL) E-Kardex kiosk. When she observed the E-Kardex kiosk, there was no documentation in regard to the application of compression stockings at 8:00am.</p> <p>During interview on 6-30-15 at 11:37am, Nurse # 1 indicated Resident # 3 had compression stockings ordered to be put on daily at 8:00am and it was documented that the compression stockings had been applied for today. Nurse # 1 walked down to Resident # 3 and indicated during observation the compression stockings had not been applied. Nurse #1 indicated another nurse had documented the compression were put on Resident #3 she had not checked when she took over the assignment. The administrative nurses were responsible for putting times the compression stockings were put on and taken off, in the kiosk and on the MAR.</p> <p>During an interview on 6-30-15 at 11:52am, the administrator indicated the compression stockings should be on the activities of daily living (ADL 's) in the kiosk as well as the medication administration record (MAR). The administrative nursing staff that was on duty was responsible for carrying out the orders.</p> <p>During an interview on 6-30-15 at 12:26pm, the director of nursing indicated the expectation was that the compression hose were put on the medication administration record and the activities of daily living (ADL) E-Kardex kiosk by the administrative nursing staff. The nurse was</p>	F 312	<p>ordered. A QI audit tool will be utilized.</p> <p>Monitors</p> <p>The QI audit tools will be submitted to the monthly quality committee for review. The quality committee will revise the plan as indicated.</p>		

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F 312	Continued From page 4 responsible for ensuring the compression hose had been put on. During an interview on 6-30-15 at 2:30pm, Nurse # 2 indicated Resident # 3 had an original order on 10-21-14 for compression stockings. The orders were supposed to be carried forward when there was no significant change during a hospital admission. During an interview on 6-30-15 at 3:52pm, the Nurse Practitioner indicated Resident # 3 required the compression stockings daily. The compression stockings were to keep the dependent edema under control. Resident #3 had a diuretic ordered to minimize the swelling from dependent edema due to her inability to move her legs. The Nurse Practitioner indicated the compression stockings needed to be applied every morning and removed every night.	F 312			