JUN 13 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345517	A. BUILDING _____ B. WING _____	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH CARE CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	This plan of correction is respectfully submitted as evidence of our allegation of compliance. The submission is not an agreement that the deficiencies existed. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	6/9/11

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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156		

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to inform 1 of 1 sampled residents (Resident #275), who was denied his preference to eat in the main dining room, about a revision in the policy regarding service in the main dining room. Findings include: A sign posted on the door of the main dining with the menus documented, "Main DR (dining room) Cut Off Times. All residents planning to have their meals in the MDR (main dining room) should arrive no later than: Breakfast 8:15 AM, Lunch 12:15 PM, and Dinner 5:15 PM." Resident #275 was admitted to the facility on 04/08/11 and readmitted on 05/13/11. The resident's documented diagnoses included protein malnutrition, diabetes, hypertension, and chronic obstructive pulmonary disease.	F 156	F 156 The sign posted for dining room meal times was replaced with just the meal times. The admission packets that contained this information were clarified to say the same. Resident # 275 has received an apology for being denied access to the main dining room. The Dining room cut off times were eliminated. In-service education regarding Resident's rights and accommodation of resident needs including clarifications in dining room hours was conducted by the facility educator to all staff. The residents will receive documented updates to these modifications of policies.	

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F 156	Continued From page 3 The resident's 04/15/11 Admission Minimum Data Set (MDS) documented his cognition was intact. On 05/16/11 at 12:20 PM Resident #275 entered the main DR in his wheelchair, awaiting placement by staff at a table. It was not until 12:25 PM that the resident was acknowledged by a staff member, the Activity Director (AD), who informed the resident that he would not be able to eat in the main DR. She stated to Resident #275, "You know what the rules are." The AD then reminded the resident that he needed to be in the main DR by 12:15 PM if he wanted to eat his lunch there. At 12:30 PM on 05/16/11 Resident #275 stated sometimes he ate his meals in his room, and sometimes he enjoyed the socialization provided by eating with other residents in the DR. He reported his preference for the 05/16/11 lunch meal was to eat with other residents in the main DR. According to Resident #275, he was not previously told there were cut off times for eating in the DR. He commented this was the first time he was denied access to DR meals. At 8:48 AM on 05/19/11 the Dietary Manager (DM) stated the policy concerning cut off times for eating in the main DR was in place when he arrived in March 2011. He reported it was his understanding that the policy only served to encourage residents to arrive on a timely basis to the DR for meals. He commented he did not think any residents who desired to eat in the main DR were ever turned away.	F 156	Staff will receive in-service education on residents rights in orientation and annually thereafter. All staff will receive in-service education for new dining room hours. Random observations of access to the main dining room for residents will be conducted weekly times 4 weeks and monthly times 2 months by the Activities director or designee. Outcomes will be reviewed at the monthly Quality Assurance meetings for 3 months and additional action taken if indicated.	6/17/11

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F 156	Continued From page 4 At 2:23 PM on 05/19/11 the AD stated Resident #275 was denied access to the main DR for his lunch on 05/16/11 because he arrived in the DR after the 12:15 PM cut off time. She reported the resident was aware of this policy regarding cut off times for service in the DR because a copy of the policy was included in the admission packet, the policy was discussed in Resident Council meetings, and periodically a copy of the policy was attached to The Daily Chronicle newsletter which was given out in activities and taken door-to-door. At 2:30 PM on 05/19/11 the Director of Nursing (DON) stated she was unsure when the cut-off times for DR service were instituted, possibly being less than a year ago. However, she reported the purpose of the new DR policy was to keep staff from having to track resident trays down from carts delivered to the halls if the residents were late arriving in the DR, possibly resulting in cold food by the time these trays were brought back to the DR. The DON also explained many of the staff working in the dining room worked in other departments in the facility, and having to wait on late-arriving residents in the DR kept them from being able to carry out their duties in these other departments on a timely basis. In interviews on 05/19/11 between 6:03 PM and 6:14 PM with 5 of 6 residents, identified as being reliable by facility staff, these residents reported never having received a copy of The Daily Chronicle. Record review revealed that a family member of Resident #275 signed all the paperwork in the resident's admission packet. Minutes from the	F 156		

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F 156	Continued From page 5 April 2011 Resident Council meeting documented the revised policy regarding service in the main DR was not reviewed. A sign-in sheet for the 05/02/11 Resident Council meeting, when cut off times for DR service were discussed, revealed Resident #275 was not in attendance. Review of Resident #275's medical record revealed no documentation that cut off times in the DR were discussed individually with the resident. The Monthly Weights documented Resident #275 lost eleven pounds between 04/08/11 and 05/04/11. At 8:33 AM on 05/20/11 Resident #275 stated he never received a copy of The Daily Chronicle before, and he never noticed cut off times for service posted on the main DR door. At 8:58 AM on 05/20/11 Nurse #1 stated Resident #275 was alert and oriented x 3, reliable, and interviewable. At 2:12 PM on 05/20/11 nursing assistant (NA #1) stated Resident #275 was very interviewable unless he was sick which caused him to be slightly confused.	F 156		
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.	F 279		

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F 279	Continued From page 6 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 observation, record review and staff interviews, the facility failed to develop a comprehensive care plan that included care of an indwelling urinary catheter for 1 of 4 sampled residents (Resident #274) who had catheters. Findings include: Resident #274 was admitted to the facility on 03/31/11 and re-admitted to the facility on 04/18/11. Cumulative diagnoses included hypertension, congestive heart failure, respirator dependent, diabetes mellitus, depression, tracheostomy, gastrostomy and pressure ulcer. A nurse's note of 04/01/11 indicated that Resident #274 was alert with unclear speech. It also indicated the indwelling urinary catheter was intact and draining yellow urine. A nurse's note of 04/04/11 at 10:45 AM indicated Resident #274's indwelling urinary catheter was discontinued. On 04/07/11 at 8:51 PM, another nurse's note in	F 279	F279 The Care plan of resident #274 was updated to include care of indwelling catheter. The Unit Coordinators will complete an audit for all current residents with indwelling catheters to assure that the appropriate catheter care plan is in place. Nurses were in serviced by the facility educator on process of care planning of residents with indwelling catheters. Random audits will be conducted by the Unit coordinator or designee, to ensure that residents with indwelling catheters have appropriate careplans. Audits will be conducted weekly for 4 weeks then monthly for 2 months. Findings will be discussed at the monthly Quality Assurance meetings for 3 months. Additional actions will be taken if indicated.	6/17/11

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F 279	Continued From page 7 Resident #274's record indicated the indwelling urinary catheter was intact. Resident #274's care plan of 04/11/11 included a problem of potential for altered skin integrity related to incontinent of bowel and bladder. Another problem identified was toileting deficit related to incontinence of bowel and bladder. There was no mention of the indwelling urinary catheter. Upon review of Resident #274's admission orders of 04/18/11, it was noted that there was no mention of an indwelling urinary catheter. A nurse's note of 04/18/11 at 5:30 PM indicated that Resident #274 arrived at the facility with an indwelling urinary catheter that was intact and draining with yellow clear urine. A resident evaluation form of 04/18/11 indicated Resident #274 had an indwelling urinary catheter. An indwelling urinary catheter assessment of 04/18/11 indicated Resident #274 had clinical justification to support initiation and/or continued use for catheter use. It was noted that the catheter was placed due to contamination of a stage 3 or 4 pressure ulcer with urine. Upon review of Resident #274's active record, there was no physician's order to place the indwelling urinary catheter. Physician progress notes were reviewed and there was no mention of indwelling urinary catheter.	F 279		

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F 279	Continued From page 8 A nurse's note of 05/13/11 indicated Resident #274 had an indwelling urinary catheter which was patent and intact. On 05/19/11 at 11:40 AM, personal care was observed. It was noted that Resident #274 had an indwelling urinary catheter attached to a drainage bag. The unit manager/unit coordinator was interviewed on 05/20/11 at 4:15 PM. She stated the indwelling urinary catheter should also be included on the resident's care plan that either she would add it or the MDS nurse would. During another interview with the ADON, on 05/20/11 at 4:50 PM, she stated if a resident had an indwelling urinary catheter it should be included on the care plan. She added that it should be included on the care plan when it was placed and not wait for the next minimum data set assessment.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to perform a gastrostomy tube (GT) placement check prior to the administration of medications on 1 of 1 (resident #2) sampled residents. Findings include: Resident #2 was admitted to the facility on	F 281	F281 Resident #2 demonstrated no adverse reaction to medication administration. Individual in-service education for Nurse #1 was conducted by the facility educator.	

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F 281	Continued From page 9 10/17/08. The resident's documented diagnoses included bilateral upper and lower extremity contractures and vegetative state secondary to anoxic encephalopathy. The Annual Minimum Data Set (MDS) of 03/08/11 for Resident #2 indicated the resident was comatose, had impairment in range of motion of bilateral upper and lower extremities, and was totally dependent on staff for personal hygiene and bathing. Resident #2's care plan, dated 03/09/11, identified self-care deficit with hygiene and bathing as a problem. Interventions to this problem included providing total assist with hygiene and bathing and monitoring skin integrity weekly. During medication pass observation conducted on 05/20/11 at 8:49 AM, Nurse #1 prepared medications for administration via gastrostomy tube for Resident #2. She went into the resident's room and placed the tube feeding pump on hold. She inserted a plastic barrel syringe into the gastrostomy tube to aspirate stomach contents. She obtained a residual of approximately 5 milliliters (ml). She flushed the tube with approximately 20ml of water then she poured the medications into the tube. Once the medications had drained in through the tube, she flushed afterwards with approximately 75 ml of water. She did not check the placement of the gastrostomy tube prior to administration of medications. Nurse #1 was interviewed immediately following the observation on 05/20/11 at 9:00 AM. She	F 281	Observations of the appropriate placement check during medication administration via gastrostomy tube will be conducted by the Facility Educator or designee for nursing staff, to assure proper policy and procedure is followed. Nurses will be re educated by the facility educator on the proper practice of medication administration for tube fed residents including checking for placement. Random observations will be made by the quality assurance coordinator or designee of nurses administering medications through a gastrostomy tube weekly for 4 weeks then monthly for 2 months to assure gastrostomy tube placement is checked prior to administration of medications. Findings will be reviewed at monthly Quality Assurance meetings for three months and further action will be taken if indicated.	6/17/11

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F 281	Continued From page 10 stated she usually checked placement of the gastrostomy tube on her second medication pass as it was a lighter administration. She stated the first medication pass of the day was usually very heavy. When questioned about what the expectation of the facility was for checking gastrostomy tube placement, she read the order from the resident's Medication Administration Record (MAR) which indicated to check residual and placement each time before medications, feedings or flushes were given. Nurse #1 stated she always checked residual before administering anything into the gastrostomy tube. She also reported that she always flushed the tube with water before and after medications. During an interview with the Assistant Director of Nurses (ADON) on 05/20/11 at 9:30 AM, she stated that staff should crush each medication individually. She stated staff should check for placement of the gastrostomy tube by injecting air into the tubing and listening with a stethoscope to verify that the tube was in the proper place before administering any medications. She added that it was a standard of nursing practice to check placement as well as their expectation.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309		

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to collect specimens as requested by the dialysis center on 1 of 1 (resident #141) sampled residents. Findings include: Resident #141 was re-admitted to the facility on 2/11/11 from an acute care hospital with diagnoses including End Stage Renal Disease (ESRD), above the knee amputation (AKA), and diabetes mellitus (DM). Resident #141's quarterly Minimum Data Set (MDS) dated 2/18/11 indicated that the resident was receiving dialysis treatments for ESRD. Resident #141 was always incontinent of bowel and needed assistance with toileting. Review of the resident's medical record revealed a Dialysis Progress Note dated 5/14/11. The Note indicated that resident #141's hemoglobin was 8.8. It requested the facility "fill out/collect times 3 bowel movements (BM) and return these with the patient to dialysis". Review of Resident #141's medical record revealed a Nurses Note dated 5/14/11 at 9:10 PM which stated, "Resident has order from dialysis to collect BM x (times) 3 and return to dialysis on next visit." Review of Resident #141's Activities of Daily Living (ADL) flow sheet indicated the resident had five bowel movements between 5/17/11 and 5/19/11.	F 309	F309 Review of records for resident #141 included ensuring that the order was transcribed and that the stool specimens were collected on 5/23, 5/24 and 5/25/11. The results were sent to dialysis center. A 100% audit of dialysis books was conducted by the unit coordinators for completion of instructions and communications from dialysis centers. Nursing staff will be in serviced by facility educator regarding checking the dialysis communication books for communications and or instructions that require follow up from the dialysis centers. Random audits of dialysis books to be conducted by the Unit Coordinator or designee weekly for 4 weeks, then monthly for 2 months, to assure dialysis communications and instructions are followed timely. Findings to be discussed at monthly Quality Assurance meetings. Further action will be taken if indicated.	6/17/11

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F 309	Continued From page 12 Review of Resident #141's Medication Administration Record (MAR) for May 1-May 31 2011, showed that the order for collecting the stool samples had not been transcribed. In an interview on 5/20/11 at 11:02 AM, nurse #2 indicated that the dialysis center communicated with the facility through the dialysis progress note. If the dialysis center needed something like a specimen it would be on the dialysis progress note. The information would be provided to the nursing assistants so they would know that a specimen was needed. The information would then be passed on in report to the oncoming shift. In an interview on 5/20/11 at 2:30 PM, nurse aide #3 indicated that she did not know resident #141 needed a specimen collected. She had received report from the third shift nursing assistant and had not been notified of a need for a bowel specimen. In an interview on 5/20/11 at 3:15 PM, nurse #3 indicated that if specimens were needed for the dialysis center a request would be written on the dialysis progress note. The nurse who received the paperwork would write a telephone order and transcribe the order to the Medication Administration Record (MAR). The information would be provided to the nursing assistants and passed on verbally in report. In an interview on 5/20/11 at 3:15 PM, nurse team leader #1 indicated it was her expectation that a telephone order be written out and transcribed to the MAR if a request for a specimen was made by the dialysis center.	F 309		

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F 309	Continued From page 13 In an interview on 5/20/11 at 4:09 PM, the Director of Nursing indicated it was her expectation that if an order was received from the dialysis center, it needed to be followed through. She would expect for the information to be communicated through report. In a telephone interview on 5/20/11 at 4:20 PM, nurse #4 indicated that she had just forgotten to transcribe the order from the dialysis center. She stated she had provided the information to the oncoming nurse in a verbal report.	F 309		
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 observation, record review and staff interviews, the facility failed to ensure that 1 of 2 sampled dependent residents (Resident #2) received a complete bed bath whose personal care was observed. Findings include: The facility's procedure for providing a bed bath, which was undated, included washing the thighs, legs and feet. It also included changing the bath water at least once during the procedure. The procedure included washing arms and to give special care to the umbilicus, folds of skin, hands and feet.	F 312	Resident #2 given the proper bed bath, with special attention to contracted areas of hands, elbows and axillary areas. Therapy staff evaluated resident for the appropriate interventions to prevent skin breakdown of contracted areas. In-service education was conducted with NA# 1.	

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F 312	Continued From page 14 The Annual Minimum Data Set (MDS) assessment of 03/08/11 for Resident #2 indicated the resident was comatose, had impairment in range of motion of bilateral upper and lower extremities, and was totally dependent on staff for personal hygiene and bathing. According to Resident #2's care plan, start date of 03/09/11, she had a self care deficit in dressing, bathing and hygiene. Interventions/approaches included range of motion with care and total assist with bathing. a. A bed bath was observed being provided to Resident #2 on 05/20/11 at 11:55 AM. Nurse Aide #1 (NA#1) prepared a basin of warm very soapy water. She began to bathe Resident #2. She washed her face with a clean washcloth and no soap. She continued bathing the upper body including the arms, the right hand, her chest and abdomen. She dried with a towel. She washed her perineal area and groins then dried with a towel. She rolled Resident #2 onto her right side and washed her back and buttocks. She placed a clean brief, a clean gown and told the resident she was finished. She did not open her left hand or attempt to wash it nor did she wash her lower extremities. She used the same washcloth for the entire bath and never changed the basin of water. NA#1 was interviewed immediately following the bed bath, on 05/20/11 at 12:15 PM. She stated that residents usually received showers twice weekly. She stated on days in between showers she gave partial bed baths. When questioned about the partial bed bath, NA#1 stated she washed the periarea and the upper body but not	F 312	Observations will be made of NA staff by Unit Managers to assure proper bathing technique is being followed. Facility educator will re-educate NA staff regarding the appropriate procedures for bed bath particularly for residents with contractures and/or difficult to reach areas. Random observations of bed baths and showers will be conducted by facility educator or designee weekly for 4 weeks, then monthly for 2 months. Findings to be discussed at monthly Quality Assurance meetings for three months. Further action will be taken if indicated.	6/17/11

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F 312	Continued From page 15 the lower extremities. She also stated that she would not change her washcloth or the bath water unless the resident had a bowel movement. NA#1 stated she always washed the buttocks area last as it was usually the most unclean. During an interview with the Assistant Director of Nurses (ADON), on 05/20/11 at 1:00 PM, she stated bed baths were given to all residents on days that they were not receiving showers. She stated a complete bed bath was to be provided and included a head to toe bath. She stated the water should be changed before providing perineal care and a clean wash cloth should be used. b. The facility's undated bed bath policy documented, "Purpose: 1. To cleanse, refresh, and soothe the resident. 2. To stimulate circulation. 3. To inspect the body. Procedure: 10. Give special care to umbilicus, folds of skin, hands and feet." Resident #2 was admitted to the facility on 10/17/08. The resident's documented diagnoses included bilateral upper and lower extremity contractures and vegetative state secondary to anoxic encephalopathy. Resident #2's 03/08/11 Annual Minimum Data Set (MDS) documented the resident was comatose, had impairment in range of motion of bilateral upper and lower extremities, and was totally dependent on staff for personal hygiene and bathing. Resident #2's care plan, dated 03/09/11,	F 312		

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F 312	Continued From page 16 identified self-care deficit with hygiene and bathing as a problem. Interventions to this problem included providing total assist with hygiene and bathing and monitoring skin integrity weekly. At 4:10 PM on 05/19/11 nursing assistant (NA) #2 stated even though Resident #2's hands were severely contracted, she had no problems cleaning them when bed baths and showers were provided to the resident. When the NA uncovered Resident #2's hands, they were dry and slightly scaly on the outside. There was no skin breakdown to the inside of the right hand. However, there appeared to be a large build-up of dead skin and redness between the resident's left thumb and forefinger. There was a slight odor which was emitted from this area. At 4:16 PM on 05/19/11 occupational therapist (OT) #1 examined Resident #2's hands. The OT removed a large amount of damp, dead skin from the reddened area between the resident's left thumb and forefinger. As the OT removed the skin there was a strong, pungent odor which was released. The OT reported because the resident's arms were contracted so tightly against her body, she wanted to examine the resident's skin in the bilateral elbow and under arm regions. There was no impairment of skin integrity on the right side of the resident's body. However, the OT remarked the skin inside the resident's left elbow and under the resident's left shoulder (in the under arm region) was reddened and excoriated. The OT stated Resident #2 should be evaluated by therapy to determine appropriate interventions to prevent skin breakdown. She explained since the resident's contractures were older in	F 312		

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F 312	Continued From page 17 formation and fixed, palm protectors probably would not be of great benefit to the resident at this late stage. However, she commented she would probably consider placing dry washcloths to absorb moisture and provide comfort at six points, the bilateral palms extending into the area between thumbs and forefingers, the bilateral elbows, and the bilateral under arms. At 11:32 AM on 05/20/11 the therapy manager (TM) stated when NAs were providing showers and bed baths, they should report compromised skin integrity to nursing. She explained a therapy evaluation would be triggered when nursing completed a nursing communication form detailing out the type of skin problem. According to the TM, excoriation, moisture build-up, and the presence of odor and large amounts of dead skin would be precursors to open wounds so the presence of these conditions in areas of severe contracture should be addressed quickly. At 11:55 AM on 05/20/11 NA #1 was preparing supplies to provide personal care to Resident #2. She gave the resident a bed bath, but did not wash the resident's left hand. It was noted that the thumb on Resident #2's left hand was pressed into her palm. NA#1 did not attempt to open the resident's hand. At 12:15 PM on 05/20/11 NA#1 stated she did not wash Resident #2's left hand because, in the past when she bathed Resident #2, the resident would pull her left arm back when she (the NA) attempted to clean it. NA#1 stated Resident #2 usually received showers twice weekly, and she would use the shower head to spray water into the resident's left hand.	F 312		

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F 312	Continued From page 18 At 2:40 PM on 05/20/11 the director of nursing (DON) stated the provision of thorough showers and bed baths, which involved the cleansing and drying of skin, was important in avoiding skin breakdown in areas of contracture.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to obtain a physician's order for the use of an indwelling urinary catheter for 1 of 4 sampled residents (Resident #274) who had catheters. Findings include: Resident #274 was admitted to the facility on 03/31/11 and re-admitted to the facility on 04/18/11. Cumulative diagnoses included hypertension, congestive heart failure, respirator dependent, diabetes mellitus, depression, tracheostomy, gastrostomy and pressure ulcer. A nurse's note of 04/01/11 indicated that Resident	F 315	F315 Physician order was obtained for use of catheter for resident #274. Unit Coordinators will complete an audit for all current residents with indwelling catheters to assure an order is in place. Nurses were in serviced by the facility educator on process of obtaining and following physician orders relating to indwelling catheters.	

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F 315	Continued From page 19 #274 was alert with unclear speech. It also indicated the indwelling urinary catheter was intact and draining yellow urine. A nurse's note of 04/04/11 at 10:45 AM indicated Resident #274's indwelling urinary catheter was discontinued. On 04/07/11 at 8:51 PM, another nurse's note in Resident #274's record indicated the indwelling urinary catheter was intact. Resident #274's care plan of 04/11/11 included a problem of potential for altered skin integrity related to incontinent of bowel and bladder. Another problem identified was toileting deficit related to incontinence of bowel and bladder. There was no mention of the indwelling urinary catheter. Upon review of Resident #274's admission orders of 04/18/11, it was noted that there was no mention of an indwelling urinary catheter. A nurse's note of 04/18/11 at 5:30 PM indicated that Resident #274 arrived at the facility with an indwelling urinary catheter that was intact and draining with yellow clear urine. A resident evaluation form of 04/18/11 indicated Resident #274 had an indwelling urinary catheter. An indwelling urinary catheter assessment of 04/18/11 indicated Resident #274 had clinical justification to support initiation and/or continued use for catheter use. It was noted that the catheter was placed due to contamination of a stage 3 or 4 pressure ulcer with urine.	F 315	Random audits will be conducted by unit coordinator or designee to assure that residents with indwelling catheters have appropriate physician orders. Audits will be conducted weekly for 4 weeks then monthly for 2 months. Findings will be discussed at the monthly Quality Assurance and additional actions will be taken if necessary.	6/17/11

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F 315	Continued From page 20 Upon review of Resident #274's active record, there was no physician's order to place the indwelling urinary catheter. Physician progress notes were reviewed and there was no mention of indwelling urinary catheter. A nurse's note of 05/13/11 indicated Resident #274 had an indwelling urinary cather which was patent and intact. On 05/19/11 at 11:40 AM, personal care was observed. It was noted that Resident #274 had an indwelling urinary catheter attached to a drainage bag The Assistant Director of Nurses (ADON) was interviewed on 05/20/11 at 3:15 PM. She stated that a physician's order should be obtained for use of indwelling urinary catheters. She stated the order should include care of the catheter. She stated the physician's order was also included on the treatment record for the nurses to ensure that catheter care was performed. She added that she had reviewed Resident #274's record and there was no physician's order. Upon review of Resident #274's record on 05/20/11 at 3:19 PM, it was noted that a telephone order had been obtained from the physician for the use of the indwelling urinary catheter for Resident #274. The ADON reported on 05/20/11 at 3:36 PM that the unit manager/coordinator reviewed justifications for use of the indwelling urinary	F 315		

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F 315	Continued From page 21 catheters but the hall nurses were responsible for obtaining the physician's order. She stated when Resident #274's re-admission orders were reviewed, it was overlooked. The unit manager/unit coordinator was interviewed on 05/20/11 at 4:15 PM. She stated that residents were admitted or re-admitted to the facility, she was responsible for completing the catheter justification form. She stated the hall nurse shall obtain the physician's order for the use of the indwelling urinary catheter. She also reported that the catheter should also be included on the resident's care plan that either she would add it or the MDS nurse would. The unit manager/unit coordinator commented that residents with indwelling urinary catheters were also discussed in the daily meetings. She stated the physician's order was missed.	F 315		
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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to label and date food items in all storage areas of the kitchen. Findings include:	F 371		

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F 371	Continued From page 22 During initial tour of the kitchen on 05/16/11, beginning at 11:03 AM, there were no labels or dates on two pitchers of tea and five carafes of juice in the reach-in refrigerator. The date on a plastic bag of sliced meat in the walk-in refrigerator was smeared and unreadable. In addition, there was not an open date on a gallon container of thousand island dressing, and there was no label and date on a plastic bag containing sliced white cheese. In the walk-in freezer there were no labels and dates on plastic bags of chicken, fish, hot dogs (2), tater tots, and cubed potatoes. In a large plastic bin beside the steam table two thirteen-ounce packages of gravy mix, a 28-ounce box of cream of wheat, a pound box of light brown sugar, and a five-pound bag of grits, all of which had been opened, did not labels and dates on them. In the dry storage room an opened 6.5-pound bag of biscuit mix, a plastic bag containing icing mix, and a plastic bag containing lemon gelatin did not have labels and dates. During a follow-up tour of the kitchen on 05/19/11, beginning at 8:52 AM, there were no labels and dates on a plastic bag containing sliced white cheese, two plastic bags containing whipped topping, two plastic bags containing sliced turkey, and a plastic container of corn on the cob stored in the walk-in refrigerator. In the walk-in freezer there were no labels and dates on plastic bags of chicken, fish, hot dogs (2), tater tots, cubed potatoes, cookie dough, and biscuits. In a large plastic bin beside the steam table a 28-ounce box of cream of wheat, a five-pound bag of grits, and a thirteen-ounce package of	F 371	F371 No residents were affected by this practice. All deficient areas were rectified by dietary staff. Nutrition service director/designee inspected all other areas having the potential to be affected by this practice. Dietary staff will be in serviced on the practice of labeling and dating of opened and re-stored items. Nutrition Services Director will complete documented audit of stored food three times a week for three months to ensure proper labeling and dating of stored food. Findings will be discussed at monthly Quality Assurance meetings for 3 months. Further action will be taken if necessary.	6/17/11

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F 371	Continued From page 23 gravy mix, all of which had been opened, did not have labels and dates on them. In the dry storage room an opened bag of marshmallows, an opened box of brownie mix, and a plastic bag containing marshmallows did not have labels and dates. At 11:42 AM on 05/19/11 the Dietary Manager (DM) stated he and the AM and PM cooks checked all storage areas, including the reach-in refrigerator, walk-in refrigerator and freezer, and dry storage room, once a day to make sure food items had labels and dates on them. He also reported the dietary employee in charge of the dry storage room monitored for dating and labeling in this area three to four times a week, including the two days each week when the facility received stock. The DM explained all leftover food items, food items in opened packaging, and food items removed from their original packaging and placed in storage containers were supposed to be labeled and dated. At 11:56 AM on 05/19/11 the AM Cook stated all storage areas in the kitchen were checked by the AM and PM cooks twice a week for labeling and dating. She reported all leftover food items, food items in opened packaging, and food items removed from their original packaging and placed in storage containers were supposed to be labeled and dated. At 3:03 PM on 05/19/11 the DM provided copies of in-servicing conducted with the dietary staff on 04/01/11 and 05/06/11 regarding the labeling and dating of leftover food items.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 24 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure that staff were handling soiled linens in a manner to prevent the spread of infection during 2 of 2 observations of soiled linens being on the floor in a resident's room. Findings include: According to the facility's policy for handling linens, which was undated, soiled or contaminated linens should be transported and stored in a manner that ensures minimal contamination. Containers for soiled linens should be used and kept covered. On 05/20/11 at 11:55 AM, the housekeeper was observed scrubbing Resident #2's roommate's floor and was beginning to scrub Resident #2's floor. It was noted that there was a pile of dirty linens on the floor on the roommate's side of the room near the doorway. Nurse Aide #1 was observed picking the dirty linens up from the floor and placing them into the soiled linen cart which was sitting just outside the room. She was wearing gloves and removed them to use a sanitizing gel to cleanse her hands. She proceeded to prepare supplies for Resident #2's bed bath. As she washed Resident #2, she removed her gown and threw it on the floor. She continued with the bath. When she was finished with the bath, she threw the towel and washcloth onto the floor. After she cleaned up her supplies from the bath, she picked the dirty linens up and took them to the soiled linen cart which was still sitting just outside the room. NA#1 was interviewed immediately following the	F 441	F441 NA# 1 received in-service education by the facility educator regarding proper handling of soiled linens to prevent the spread of infection. Infection Control nurse or designee will observe nursing staff on handling of soiled linens. Staff that demonstrate competency difficulty will be re-educated. Staff will be re-educated by facility educator regarding infection control policy and procedure for proper handling of soiled linens. This is also addressed in general orientation. Random observations to be made by infection control nurse or designee on proper handling of soiled linens weekly for 4 weeks, then monthly for 2 months. Findings will be discussed at monthly Quality Assurance meetings for 3 months. Further actions will be taken if indicated.	6/17/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345517	A. BUILDING _____ B. WING _____	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH CARE CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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F 441	Continued From page 26 bed bath on 05/20/11 at 12:15 PM. She stated she was not allowed to carry dirty linens in the hallway unless they were in a plastic bag. She also stated that she had not been told specifically that she could not throw the dirty linens on the floor. When questioned about the facility's policy for infection control, NA#1 stated she was not sure what the policy was. An interview was held with the infection control nurse on 05/20/10 at 11:57 AM. She stated that soiled linens were to be bagged in the resident rooms to prevent the spread of infection. She commented that soiled linens were never to be thrown on the floor in resident's rooms. The infection control nurse stated that nurse aides were taught to place linens and clothes in bags immediately after removing. She stated the plastic bag should be prepared before the bed bath was started. She added that nurse aides were taught to place linens in plastic bags during orientation. The infection control nurse stated that spot checks were done on each unit to ensure compliance. She stated that resident's clothing should be taken to the dirty utility room and not placed in the dirty linen carts on the hall. The infection control nurse commented that if dirty linens were thrown on the floor as it has the potential to spread infection. She stated there had been a recent inservice on handling linens.	F 441		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345517	A. BUILDING 01 - MAIN BUILDING B. WING	06/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH CARE CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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K 000	INITIAL COMMENTS By observation on 6/21/11 a magnetic locking system was in initial stages of being installed. The facility was made aware of the review process through the Department of Health Services Regulation.	K 000	This plan of correction is respectfully submitted as evidence of our allegation of compliance. This plan of correction is not an admission that the deficiencies actually existed or that we are in agreement with the deficiencies cited. It is however our expression of a desire to comply and correct any deficiencies cited.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/21/11 at approximately noon the following exit access was non-compliant, specific findings include; A. The door exiting the kitchen to the dining room had a dead bolt that required more than one range of motion to exit the area. B. The dining courtyard had three doors that could be used for exit access. One of the two required means of egress, that was signed for exit access, had passage hardware that could be locked. Exit access must be readily accessible at all times.	K 038	1. A.Dead bolt has been removed from the door exiting the kitchen leaving only a single lock in place. B. The passage hardware that could be locked was replaced by a regular hardware handle without a lock option. This was the egress that was signed for the exit access. 2. An observation round by the Director of Maintenance was completed on all exit access doors to assure that exits were readily accessible at all times. 3. Exit access door accessibility will be part of general maintenance monthly rounds. 4. Documented rounds of exit access doors will be completed by the Director of Maintenance or designee monthly times three months. Outcomes will be reviewed at the monthly QA meetings for 3 months and additional action taken if indicated.	6/22/201
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	1. Simplex Grinnell to install required electronically supervised tamper alarm. 2. Maintenance Director will research and update sprinkler system as necessary.	

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

DIRECTOR OF ENVIRONMENTAL SERVICES 7-6-11

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.

DRW

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345517	A. BUILDING 01 - MAIN BUILDING B. WING _____	06/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH CARE CENTER	3030 BLUE RIDGE ROAD RALEIGH, NC 27612

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K 061	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/21/11 at approximately noon the following automatic sprinkler system was observed as non-compliant, specific findings include the accelerator line to the dry side of the sprinkler risers, system #1, #2 & #3, had a valve that when closed will affect the operation of the system and is not equipped with an electronically supervised tamper alarm.	K 061	3.Quarterly inspection of sprinkler system will be done by Maintenance Director/Simplex sprinkler system vendor. 4. Quarterly inspection of sprinkler system outcomes will be reviewed during the Quarterly Quality Assurance meetings.	8/1/2011
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications, 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/21/11 at approximately noon the following Heating Ventilation and Air Conditioning (HVAC) Units were observed as non-compliant, specific findings include four out of five units supplying conditioned air to the corridors were not functioning properly on the 100, 200, & 300 halls. The surveyor was told that the units were in the process of being replaced with corporate approval already obtained. The through the walls units in each of the patients rooms were not affected. Fans in the corridor were used during the temporary high	K 067	1. All HVAC units in system #1, #2, and #3 are currently being replaced. 2. Scheduled maintenance will be performed by Maintenance Director and HVAC contracted company. 3. Maintenance contract has been established with HVAC company for regularly scheduled maintenance service. 4. Routine inspection outcomes will be reviewed during the Quarterly Quality Assurance meeting.	8/1/2011

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	345517	A. BUILDING 01 - MAIN BUILDING B. WING _____	08/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 067	Continued From page 2 temperature to maintain ASRAE standards.	K 067		