Blowing Rock Hospital
Member of Appalachian Regional Healthcare System

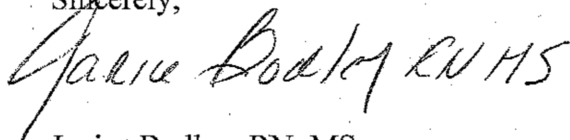
September 21, 2011

Karen Roquemore, R.N., BSN
Facility Survey Consultant
NC DHHS Division of Health Service Regulation
Nursing Home Licensure & Certification Section
Western Regional Office
952 Old US Hwy 70
Black Mountain, NC 28711

Dear Ms. Roquemore,

As per your request of September 19, 2011, please find enclosed our revised Plan of Correction for the deficiencies which you found during your recertification survey from August 22, 2011 to August 25, 2011. Thank you.

Sincerely,



Janice Bodley, RN, MS
Director Patient Care Services
Blowing Rock Hospital, Inc.

JB/mck

Enclosures

418 Chestnut Drive • P.O. Box 148 • Blowing Rock, NC 28605 • Tel 828.295.3136 • *www.apprhs.org*

North Carolina Department of Health and Human Services
Division of Health Service Regulation • Nursing Home Licensure and Certification Section
Tel 828-669-3372 • Fax 828-669-3382
Western Regional Office • Black Mountain, North Carolina 28711-4501
http://www.ncdhhs.gov/dhsr/

Drexdal Pratt, Director

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Beverly Speroff, Section Chief

IMPORTANT NOTICE - PLEASE READ CAREFULLY

September 19, 2011

Mr. Timothy Ford, CEO
Blowing Rock Hospital LTC
418 Chestnut Street
Blowing Rock, NC 28605

jbodley@apprhs.org

Dear Mr. Ford:

The Plan of Correction for the survey dated August 25, 2011 is not acceptable for the following reason(s):

Your PoC for the deficiencies must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State.

Each tag must include each of the above actions, in your Plan of Correction. The letter(s) indicate which action that particular tag is lacking:

- F- 242 - How will showers be monitored for residents who are unable to participate in the Quality of Life Survey?
- F-309 - How will printing the report every three days capture the necessary information to assure residents have regular bowel movements?
- F- 364 – Will test trays be included as part of monitoring of food for proper temperatures?
- F- 366 – What measures will be put on place for residents who are unable to participate in the Quality of Life Survey?

Please make needed corrections and return as soon as possible. **Failure to submit an acceptable PoC by the date noted in your original notice may result in additional remedies.** If you have any questions, please contact me. Thank you for your immediate attention in this matter.

Sincerely,

Karen Roquemore/mh

Karen Roquemore, RN
Facility Survey Consultant

KR/mh

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility failed to thoroughly investigate one (1) allegation of resident abuse. (Resident #27) The findings are 1. Review of the facility's "Policy for Investigating Allegations of Abuse, Neglect, and Exploitation" revealed, "All reported types of incidents would be investigated to identify all staff members involved." Resident #27 was admitted to the facility 11/10/10 with diagnoses of Anemia, Hypertension, Dementia, Anxiety, and Bipolar Disease. Review of the most recent Minimum Data Set (MDS) dated 6/27/11 revealed she was alert, oriented and able to be interviewed. The MDS also indicated she required extensive assistance with bed mobility, dressing, toileting and personal hygiene and she had exhibited no behaviors during the evaluation period. Review of the 6/23/11 abuse allegation revealed on 6/18/11, Resident #27 reported to the nurse she was afraid and scared because she had been sexually assaulted two (2) days prior to the	F 226	F 226 The Director of Nursing, Facility Social Worker and ARHS Director of Case Management met to review the details surrounding the identification, investigation and reporting of the potential abuse involving resident # 27. As a result of this meeting recommendations were made related to staff education needs and policy revisions. The policy and procedure for <u>Investigating Allegations of Abuse, Neglect, and Exploitation</u> has been revised and the name changed to <u>Abuse Prevention and Reporting.</u> It states: **Clarification and changes in the internal investigation process include:** **Internal Investigation of Allegations and Response** <u>Final Investigation Report.</u> All investigations will be completed and faxed within 5 working days to the Division of Health Services Regulation. The investigator will report the conclusion of the investigation in writing to the Administrator and notify the health care registry if the allegation is determined to be valid and involves mistreatment of a resident by a health care worker. The final investigation report shall contain the following: Continued on page 2	09/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy R. Ford — TITLE: CEO — (X6) DATE: 21 September 2011

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

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F 226	Continued From page 1 allegation. Review of the "Abuse and Neglect Reporting Form" revealed the Social Worker (SW) had started an investigation on 6/23/11. The form had N/A (not applicable) marked for the type of violation reported, even though sexual abuse was a choice for selection. The SW further documented, "When asked where this happened, she stated no to the all locations she had been such as the hospital...She was redirected and has had no further concerns." Under the "Action Taken" section, the following was documented, "Investigation completed; physician notified and stated due to recent complications wit mental illness he felt there was no validity to it (the allegation) but would monitor and if it was said again we would do an exam within the acceptable time frame..." There was no documentation staff was interviewed on previous shifts or questioned about the resident's allegation. There was no documentation of how the resident was protected from further abuse during the time of the investigation. The facility had no evidence the resident's allegation was taken seriously and thoroughly investigated to ensure she was safe. Interview with the SW on 8/23/11 at 5:02 p.m. revealed she was responsible for completing all investigations for allegations of abuse. The SW stated she had not documented any interviews conducted with staff and that only random interviews were conducted. She stated the resident had originally reported the allegation to the Nursing Assistant (NA), but the facility had not obtained a written statement. The SW further	F 226	F 226 continued..... 1. Name and mental status of the resident allegedly abused or neglected. 2. The Original Allegation (note day, time, location, the specific allegation, by whom, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries). 3. Facts determined during the process of the investigation, review of medical record and interview witnesses. 4. Conclusion of the investigation based on known facts. 5. If the allegation is determined to be valid and the perpetrator is an employee, include on a separate sheet the employee's name and current status (still working, suspended or terminated). 6. Attach a summary of all interviews conducted, with the names and willingness to testify of all witnesses. 7. The VP of Quality and Risk Management or their designee will review the report to determine completeness and provide input and direction if applicable. The appointed investigator is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the Division of Health Services Regulation within five working days of the reported incident. Continued on page 2 a	

Blowing Rock Hospital, LTC
418 Chestnut Drive
Blowing Rock, NC 28605

Provider ID # 345045

Survey Completion Date: 08/25/2011

POC	Completion Date
Page 2 a F 226 continued.............	
Immediate measures and systemic practices to be put into place:	
I. EDUCATION	
Educational presentation for nursing staff in direct patient care	09/22/11
Educational presentation for key leadership staff that may direct the initial response, reporting and investigation	09/22/11
Key components of education: 1. Abuse Definitions 2. Flow Chart : a.) Reporting structure and follow-up responsibilities for direct care staff. b.) Reporting structure and follow-up responsibilities for leadership staff directing the first response and investigation. 3. Review of Abuse Allegation Follow-up and Investigation Packet with applicable form 24 Hour Initial Report of Notification of Facility Allegation to HCPR.	09/22/11
II. POLICY REVISIONS According to the revised policy compliance to policy during the investigation process will be validated by the Appalachian Regional Health System VP of Risk Management and Quality. According to policy: The VP of Quality and Risk Management or their designee will review the report to determine completeness and provide input and direction if applicable.	09/15/11

Continued on page 2 b

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Survey Completion Date: 08/25/2011

POC Completion Date

F 226 continued.............

The Quality Assurance Tool will be utilized to check for compliance in key identified areas.

1. The Original Allegation (note day, time, location, the specific allegation, by whom, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries)
2. Facts determined during the process of the investigation, review of medical record and witness interviews.
   Statements from all individuals who have cared for the resident during the time periods that the alleged abuse occurred.
3. Summary of all interviews conducted.
4. Conclusion of the investigation based on known facts 09/15/11

III. QUALITY IMPROVEMENT COMMITTEE

According to revised policy – "Any investigation that concluded that abuse occurred shall be reviewed by the facility Quality Improvement Committee for possible changes in facility practices to ensure that similar events do not occur again". 09/15/11

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F 226	Continued From page 2 commented the nurse who documented the allegation in the nurse's notes was no longer employed by the facility. The SW communicated since the physician thought the resident's allegation was unfounded based on her diagnoses, she didn't feel it needed to be investigated further.	F 226	F 241 Corrective Action for residents identified who have been affected by the deficient practice. Immediate follow-up and coaching with involved staff LPN #1 and CNA #2 and CNA #3. LPN #1 and CNA #2 were found to be on the list of class attendees for the Person Directed Care /Resident Rights Presentation at Competency Lab in June. 2011. CNA #3 did not attend and was scheduled for this presentation (which is now being offered at Clinical Orientation) on 09/20/2011. Corrective action for others who have the potential to be affected by the same deficient practice and corrective action to be taken (including those residents who have been affected by the deficient practice). An in-service presentation was developed for facility nursing staff and initiated on 09/12/2011. This included education on: 1. Regulation 483.15 with discussion on resident directed care and its impact on dignity and respect. Continued on page 3 a	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to knock on doors or ask permission to enter prior to entering six (6) resident rooms. The findings include: On 8/25/11, 1:35 p.m. and 1:50 p.m., NA #'s 2 and 3, and Licensed Practical Nurse (LPN) #1, were observed entering six (6) rooms on the second floor without knocking or asking permission to enter when delivering meal trays. At 1:33 p.m., LPN #1 said, "I only knock if the door is closed. I usually don't pass trays, but I should have knocked." Interview with the Director of Nursing (DON), on 8/25/11 at 1:50 p.m., revealed she expected everyone to knock on resident's room doors prior to entry. The DON said, "It is gone over during orientation regarding the resident's right to privacy." The DON further	F 241		

POC	Completion Date

F 241 continued……

2. Residents Rights including the facility responsibility to promote an environment that maintains and enhances dignity and respect.

- Expectations that staff carries out activities and interact with residents in a way that maintains and enhances their self esteem and self-worth.
- Respecting residents' private space and property.
- Requesting permission to enter resident rooms.
- Closing doors as requested and not inspecting personal belongings without permission. — 09/22/11

Clinical Orientation for all newly hired licensed nurses (initiated on 08/30/11)
Includes lecture and a small group game session related to resident rights and person directed care. Privacy/Dignity/ and Respect as it relates to knocking on resident doors prior to entering will be reinforced and specifically addressed including:

- Expectations that staff carries out activities and interact with residents in a way that maintains and enhances their self esteem and self-worth.
- Respecting residents' private space and property.
- Requesting permission to enter resident rooms.
- Closing doors as requested and not inspecting personal belongings without permission.

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Provider ID # 345045

Survey Completion Date: 08/25/2011

POC Completion Date

F 241 continued.....

This will be initiated into the next Orientation. 09/20/11

Immediate measures and systemic practices to be put into place.
A Resident Quality of Life Survey was developed on 09/12/11 to include—related to dignity and respect—staff respect privacy by knocking on resident doors prior to entering.
This survey includes:

- The question "Do staff members knock on your door before entering your room?"

Observation will also be completed while conducting the Quality of Life Survey for staff compliance to knocking on resident doors prior to entering. 09/12/11

Monitoring Process.
Facility staff including the Certified Dietary Manager, Registered Dietitians, ADON's and their designees will conduct the surveys. Sample selection will include five residents starting in chronological order of room numbers on each floor. These residents will be given the survey weekly initiating the week of 09/19/11. This survey will be conducted through December 31, 2011. The ADON or designee will collect and aggregate survey data to determine need for re-evaluation of current processes and follow-up for involved staff. These findings and any variances will be reported to the Performance Improvement Committee during the 4th quarter Quality Improvement Meeting in January 2012. The outcomes of the study will be evaluated, and monitoring will be continued or discontinued based on committee recommendations. 09/19/11

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F 241	Continued From page 3 commented she had just given a training regarding resident rights. Review of the training record revealed NA #'s 2 and 3 did not attend the training, but LPN #1 did attend.	F 241	F 242 Corrective Action for resident identified who has been affected by the deficient practice. The resident bath was completed the evening of 08/24/2011 and she was scheduled for day time whirlpool baths three times per week as requested.	8/24/11
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to provide showers per one (1) of three (3) sampled resident's choice. (Resident #66) The findings are: Resident #66 was admitted to the facility on 8/18/11. Diagnoses included a sacral ulcer, paraplegia, reactive airway disease and malnutrition. The admission nursing assessment dated 8/18/11 at 6:15 a.m. noted Resident #66 had no cognitive impairments and was independent in decision making. The assessment checked her bathing preference was a whirlpool during the day time hours with a hand written notation that she mainly preferred baths in the morning or whenever. She required minimal assistance with	F 242	Corrective action for others who have the potential to be affected by the same deficient practice and corrective action to be taken. An in-service presentation was developed for nursing staff to address survey deficiencies, provide education and brainstorm solutions for improvement in the facility. These sessions initiated on 09/12/2011 include education on: • Regulation 483.15 with discussion on facility expectations to "create an environment that is respectful of the right of each resident to exercise his/her autonomy regarding what the resident considers to be important facets of his / her life". • Residents Rights including the right to make choices about aspects of their life in the facility that are significant to them. • Clinical Orientation for all newly hired licensed nurses (initiated on 08/30/11) includes lecture and a small group game session related to resident rights and person directed care. The right of the resident to exercise autonomy regarding what the resident considers to be important facets of his / her life will be reinforced, the scenario of respecting choices in bath type and time of day for bathing will be included. Continued on page 5	9/22/11

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F 242 Continued From page 4

bathing per this assessment. This admission nursing assessment was signed as completed by the Assistant Director of Nursing (ADON) #1.

An interim care plan included the interventions to assist and provide baths twice a week.

On 8/23/11 at 9:10 a.m. Resident #66 stated that when she arrived at the facility, someone asked her if she preferred a bath or a shower. She stated as of this date, she has not received a bath or a shower.

On 8/24/11 at 3:32 p.m. Resident #66 was coming out of the ADON #1's office. Resident #66 confirmed she had no bath or shower since admission and was just speaking to the ADON #1 about it.

On 8/24/11 at 3:54 p.m. Interview with the ADON #1 revealed she made arrangements for Resident #66 to get a bath this evening and three times each week per the resident's request. She further stated Resident #66 had not been bathed since admission. She stated she placed the bath schedule on the nurse aide assignment sheets daily based on a main sheet with room numbers and days for showers twice a week. Review of this sheet showed the room number for Resident #66 was crossed out. The ADON #1 missed placing Resident #66's shower on the nurse aide's assignment sheet and confirmed Resident #66 had not received a bath or shower since admission.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must

F 242 F 242 continued........

Immediate measures and systemic practices to be put into place.

A Resident Quality of Life Survey was developed on 09/12/2011 to include specific questions about their satisfaction with bathing:

- Do you receive your baths twice a week
- Do you wish to make changes to the day or time of day which you receive your bath? — 09/19/11

Residents who are not able to participate in the Quality of Life Survey were identified (completed 09/20/11). The ADON or their designee will review the bath schedule assignment sheets daily for these residents. Staff is to highlight completed baths on the schedule. Baths not completed will be scheduled for the next day by the ADON or their designee. — 09/20/11

Monitoring Process.

For Quality of Life Survey Participants

Facility staff including the Certified Dietary Manager, Registered Dietitians, ADON's and their designees will conduct the Quality of Life surveys. Sample selection will include five residents starting in chronological order of room numbers on each floor. These residents will be given the survey weekly initiating the week of 09/19/11. This survey will be conducted through December 31, 2011. — 09/19/11

F 309

Continued on page 5 a

Department of Health and Human Services / Centers for Medicare & Medicaid Services

Blowing Rock Hospital, LTC
418 Chestnut Drive
Blowing Rock, NC 28605

Provider ID # 345045

Survey Completion Date: 08/25/2011

POC	Completion Date
 F 242 continued........	
For Residents Unable to Participate in the Quality of Life Survey	
A "Weekly Bath Compliance Worksheet" was developed as a quality assessment tool (completed 09/21/11). The ADON or designee will monitor this for compliance to facility standard of two baths per week. Two staff members must validate any bath refusal. The monitoring will initiate 09/22/11 through December 31, 2011.	09/22/11
For Both Monitoring Methods	
The ADON or designee will collect and aggregate survey data to determine need for re-evaluation of current processes and follow-up for involved staff. These findings and any variances will be reported to the Performance Improvement Committee during the 4th quarter Quality Improvement Meeting in January 2012. The outcomes of the study will be evaluated, and monitoring will be continued or discontinued based on committee recommendations.	09/22/11

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F 309

Continued From page 5

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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews the facility failed to monitor residents for constipation and administer physician's standing orders for three (3) of ten (10) sampled residents. (Resident #8, #20, #46)

The findings are:

1. Resident #20 was admitted on 03/16/11 with diagnoses including Dementia. A significant change minimum data set (MDS) dated 06/28/11 revealed Resident #20 had severely impaired cognition, was usually understood, and required extensive assistance with toileting and personal hygiene. The significant change MDS did not list constipation as a problem.

Review of the facility's current physician's standing orders revealed the following interventions for constipation: "Senekot-S (laxative) two (2) tablets at bedtime as needed for constipation and Ducolax (laxative,stimulant) suppository inserted rectally once if Senokot-S not effective." The standing order did not include instructions regarding when to implement the interventions for constipation.

Review of Resident #20's computer generated list

F 309

F 309

<u>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</u>

Identified residents were assessed during the survey period and bowel reports run through the Point Click Care documentation system. Identified residents bowel movement history indicated normal, regular bowel movements in the 3 day range.
Resident #8 – Bowel movement 08/22/11 and 08/23/11
Resident #20 – Bowel movement 08/23/11 and 08/24/11
Resident #46 – Bowel Movement 08/22/11 and 08/24/11

08/24/11

<u>Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice (including those residents found to have been affected by the deficient practice).</u>

An in-service presentation was developed for nursing staff to address survey deficiencies, provide education and brainstorm solutions for improvement in the facility. These sessions initiated on 09/12/2011 include education on:

- Regulation 485.25 with resident scenario and discussion of facility expectations to provide the "highest level of functioning and well being possible by competently and thoroughly addressing the physical, mental and psychosocial needs of the individual resident".
- Revision and expectations related to the policy and procedure on Assessment and Monitoring of Bowel Function.

09/22/11

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F 309	Continued From page 6 of bowel movements (BMs)from 07/02/11 through 08/24/11 revealed the following: - No bowel movements recorded from 07/13/11 through 07/16/11. (Four (4) days) - No bowel movements recorded from 07/31/11 through 08/04/11. (Five (5) days) - No bowel movements recorded from 08/15/11 through 08/18/11. (Four (4) days) Review of Medication Administration Records (MARs) revealed Resident #20 received a laxative tablet by mouth daily beginning on 05/24/11. Review of July 2011 MAR and the current August 2011 MAR through 08/24/11 revealed Resident #20 was administered no additional interventions for constipation per the current physician's standing orders noted on the medical record. During an interview on 08/24/11 at 3:15 PM Licensed Practical Nurse (LPN) #2 stated nursing assistants (NAs) record resident BMs in an electronic documentation system and let her know who needed a laxative. LPN #2 further stated she typically administered a laxative when a resident had no BM for three (3) days, and asked alert and oriented residents if they needed a laxative during medication pass. In addition, LPN #2 explained if she could not determine the number of days a resident had been without a BM she could ask someone to access the computer generated list for her to review. An interview with LPN #3 on 08/25/11 at 9:30 AM revealed she relied on NAs to inform her of residents without a BM for three (3) days. LPN #3 stated she typically assessed as a resident for constipation if they were not eating well and/or	F 309	F 309 continued ..... Clinical Orientation for all newly hired licensed nurses (initiated on 08/30/11) includes lecture and a small group game session related to resident rights and person directed care. The policy on Assessment and Monitoring of Bowel Function and revisions will be integrated into the curriculum on 09/20/2011. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Revision on policy Assessment and Monitoring of Bowel Function in patients/residents of BRH and Extended Care Facility to include "Bowel Elimination Reports" will be run from Point Click Care by the ADON or designee on Extended Care residents three times weekly. These reports will contain 5-7 days of bowel elimination data. This data will assist in identification of bowel function problems including patients/residents with no bowel movement for 3 days. These reports will be given to the licensed nurse for follow-up to ensure residents will receive appropriate intervention which may include, but not be limited to, resident assessment/interview, non-pharmacological approaches and/or standing orders. The nurse will document initiation and effectiveness of interventions in the medical record. Continued on page 8	09/22/11

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F 309	Continued From page 7 voiding less frequently. An interview with NA #5 on 08/25/11 at 2:00 PM revealed NAs record BMs in the electronic documentation system as they occur, but were not able to review previously recorded data. NA #5 also stated she notified the nurse if aware of a resident without a BM for three (3) days. During an interview on 08/25/11 at 2:15 PM the Assistant Director of Nursing (ADON) #1 revealed the electronic documentation system used by the NAs was the only place resident bowel movements were recorded. ADON #1 stated this data was not reviewed by anyone on a regular basis and indicated she would need to come up with a better way to monitor residents for constipation. The interview further revealed ADON #1 expected licensed nursing staff to administer interventions for constipation after a resident had no recorded BM for three (3) days. An interview was conducted with the Director of Nursing (DON) on 08/25/11 at 3:25 PM. During the interview the DON confirmed a review of resident bowel movements recorded by the NAs was not part of the licensed nurses daily work plan. 2. Resident #8 was admitted to the facility on 04/07/11 with diagnoses including Dementia and a History of Hemorrhagic Cerebrovascular Accident (CVA). A quarterly Minimum Data Set (MDS) dated 07/23/11 revealed Resident #8 had moderately impaired cognition, unclear speech and was sometimes understood. The quarterly MDS indicated Resident #8 required extensive assistance with toileting and personal hygiene,	F 309	F 309 continued.... Monitoring Process. 10 random residents will be selected for monthly review in September, October, November, and December. Criteria for selection: • Residents due for quarterly IDT Care Planning in the month monitored. • Every other resident in alphabetical order will be selected to achieve 10 participants. The ADON or designee will collect and aggregate data related to failure to follow policy expectations. These results will result in re-evaluation of current processes and follow-up for involved licensed nurses. These findings and any variances will be reported to the Performance Improvement Committee during the 4th quarter Quality Improvement Meeting in January 2012. The outcomes of the study will be evaluated, and monitoring will be continued or discontinued based on committee recommendations.	09/22/11

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	345045	A. BUILDING ______ B. WING ______	08/25/2011

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F 309	Continued From page 8 was always incontinent of urine, and frequently incontinent of bowels. The quarterly MDS did not list constipaion as a problem. Review of the facility's current physician's standing orders revealed the following interventions for constipation: "Senekot-S (laxative) two (2) tablets at bedtime as needed for constipation and Ducolax (laxative,stimulant) suppository inserted rectally once if Senokot-S not effective." The standing order did not include instructions regarding when to implement the interventions for constipation. Review of Resident #8's computer generated list of bowel movements (BMs) from 07/02/11 through 08/24/11 revealed the following: - No bowel movements recorded from 08/06/11 through 08/09/11. (Four (4) days) Review of Resident #8's current August 2011 Medicatin Administration Record (MAR) revealed no physician's order for a routine stool softener or laxative. Further review of Resident #8's current August 2011 MAR through 08/24/11 revealed no interventions for constipation were adminstered per the current physician's standing orders. During an interview on 08/24/11 at 3:15 PM Licensed Practical Nurse (LPN) #2 stated nursing assistants (NAs) record resident BMs in an electronic documentation system and let her know who needed a laxative. LPN #2 further stated she typically administered a laxative when a resident had no BM for three (3) days, and asked alert and oriented residents if they needed a laxative during medication pass. In addition, LPN #2 explained if she could not determine the	F 309		

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F 309	Continued From page 9	F 309		

number of days a resident had been without a BM she could ask someone to access the computer generated list for her to review.

An interview with LPN #3 on 08/25/11 at 9:30 AM revealed she relied on NAs to inform her of residents without a BM for three (3) days. LPN #3 stated she typically assessed as a resident for constipation if they were not eating well and/or voiding less frequently.

An interview with NA #5 on 08/25/11 at 2:00 PM revealed NAs record BMs in the electronic documentation system as they occurred, but were not able to review previously recorded data. NA #5 also stated she notified the nurse if aware of a resident without a BM for three (3) days.

During an interview on 08/25/11 at 2:15 PM the Assistant Director of Nursing (ADON) #1revealed the electronic documentation system used by the NAs was the only place resident bowel movements were recorded. ADON #1 stated this data was not reviewed by anyone on a regular basis and indicated she would need to come up with a better way to monitor residents for constipation. The interview further revealed ADON #1 expected licensed nursing staff to administer interventions for constipation after a resident had no recorded BM for three (3) days.

An interview was conducted with the Director of Nursing (DON) on 08/25/11 at 3:25 PM. During the interview the DON confirmed a review of resident bowel movements recorded by the NAs was not part of the licensed nurses daily work plan.

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3. Resident #46 was admitted to the facility on 8/20/08 and readmitted 3/1/11. Diagnoses included Diabetes, Parkinson's Disease, Alzheimer's Disease, anemia, vitamin D deficiency, and gastroesophageal reflux disease.

Review of the July 2011 and Augsut 2011 physician orders revealed Resident #46 was ordered Miralax (laxative/stimulant) 17 grams daily and and evening dose of Miralax as needed.

The annual Minimum Data Set (MDS) dated 8/9/11 coded Resident #46 with severe cognitive impairment. Resident #46 was coded as needed limited assistance with toileting and being frequently incontinent of bowel.

Review of the documented bowel movements (BM) completed by the nursing assistants for Resident #46 revealed Resident #46 had no bowel movements documented as follows:
*7/9/11 through 7/18/11 = 11 days;
*7/21/11 through 7/29/11 = 9 days;
*8/5/11 through 8/9/11 = 5 days; and
*8/16/11 through 8/21/11 = 6 days.
Some days were unaccounted for on the documentation.

Review of the July 2011 and August 2001 Medication Administration Records revealed Resident #46 received no "as needed" doses of Miralax.

During an interview on 08/24/11 at 3:15 PM Licensed Practical Nurse (LPN) #2 stated nursing assistants (NAs) record resident BMs in an electronic documentation system and let her know who needed a laxative. LPN #2 further

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stated she typically administered a laxative when a resident had no BM for three (3) days, and asked alert and oriented residents if they needed a laxative during medication pass. In addition, LPN #2 explained if she could not determine the number of days a resident had been without a BM she could ask someone to access the computer generated list for her to review.

An interview with LPN #3 on 08/25/11 at 9:30 AM revealed she relied on NAs to inform her of residents without a BM for three (3) days. LPN #3 stated she typically assessed as a resident for constipation if they were not eating well and/or voiding less frequently.

An interview with NA #5 on 08/25/11 at 2:00 PM revealed NAs record BMs in the electronic documentation system as they occur, but were not able to review previously recorded data. NA #5 also stated she notified the nurse if aware of a resident without a BM for three (3) days.

During an interview on 08/25/11 at 2:15 PM the Assistant Director of Nursing (ADON) #1 revealed the electronic documentation system used by the NAs was the only place resident bowel movements were recorded. ADON #1 stated this data was not reviewed by anyone on a regular basis and indicated she would need to come up with a better way to monitor residents for constipation. The interview further revealed ADON #1 expected licensed nursing staff to administer interventions for constipation after a resident had no recorded BM for three (3) days.

An interview was conducted with the Director of Nursing (DON) on 08/25/11 at 3:25 PM. During

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F 309	Continued From page 12 the interview the DON confirmed a review of resident bowel movements recorded by the NAs was not part of the licensed nurses daily work plan.	F 309	F 312 <u>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice</u>	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide nail care for two (2) of four (4) residents reviewed for activities of daily living. (Resident #8 and #20) The findings are: 1. Resident #8 was admitted to the facility on 04/07/11 with diagnoses including Dementia, a History of Hemorrhagic Cerebrovascular Accident (CVA), and Diabetes Mellitus. A quarterly Minimum Data Set (MDS) dated 07/23/11 revealed Resident #8 had moderately impaired cognition, unclear speech,and was sometimes understood. The quarterly MDS indicated Resident #8 required extensive assistance with personal hygiene and bathing. In addition, the quarterly MDS noted Resident #8 had impaired range of motion of both extremities on one side of her body. A care plan dated 05/02/11 identified Resident #8	F 312	Identified residents were assessed during the survey period and fingernail care was provided for residents #8 and # 20 on 08/25/2011. <u>Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice (including those residents found to have been affected by the deficient practice).</u> Diabetic and residents with PVD who require more skilled nail care services were identified by pharmacy and nursing to be followed by the Skin Integrity Resource RN (Completed 09/16/11). An in-service presentation was developed for nursing staff to address survey deficiencies, provide education and brainstorm solutions for improvement in the facility. These sessions initiated on 09/12/2011 include education on: • Regulation 485.25 - <u>ADL Care Provided for Dependent Residents</u> with resident scenario and discussion of facility expectations that the resident receives care and services needed because he or she is unable to perform activities of daily living and is dependent on the staff to meet basic needs. • Revision and expectations related to the policy and procedure on Nail Care. Continued on page 14	08/25/11 09/16/11 09/22/11

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F 312	Continued From page 13 as at risk for a self care deficit due to cognitive impairment related to CVA, Dementia, and Impaired Mobility. Interventions included: "Keep/Assist resident to keep hair and nails clean and well groomed." During an interview on 08/22/11 at 3:35 PM Resident #8 indicated her finger nails needed to be trimmed. Observations made during the resident interview on 08/22/11 at 3:35 PM revealed several finger nails extended approximately 1/8 of an inch beyond her finger tip including the index, middle, and ring finger of her contractured right hand. No skin breakdown or irritation was noted in the palm of her right hand. A subsequent observation on 08/24/11 at 3:30 PM revealed several finger nails extended approximately 1/8 of an inch beyond her finger tip. An interview with nursing assistant (NA) #4 on 08/25/11 at 9:30 AM revealed she had showered Resident #8 on 8/24/11 and cleaned under her finger nails. NA #4 further stated NAs were not allowed to trim finger nails of Diabetic residents and she informed the nurse when a Diabetic resident had nails in need of a trimming. During an interview on 08/25/11 at 9:35 AM Licensed Practical Nurse (LPN) #3 stated NA #1 (Restorative Nursing) monitored and provided nail care to residents. An interview was conducted with the Assistant Director of Nursing (ADON) #1 on 08/25/11 at 2:10 PM. The ADON #1 stated NA #1 filed Diabetic residents' finger nails and maintained a	F 312	F 312 continued .... Clinical Orientation for all newly hired licensed nurses (initiated on 08/30/11) includes lecture and a small group game session related to resident rights and dignity. The revised Policy on Nail Care will be integrated into the curriculum on 09/20/11. <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</u> The policy <u>Nail Care</u> was revised to include the following changes: • The Skin Integrity RN will round on all residents with diabetes or peripheral vascular disease weekly and ensure that finger nails are clean and trimmed and facilitate podiatry consults. • The new admission skin care assessment will include identification of residents in need of skilled nail care (PVD, Diabetes). • The ADON or designee will round on all other residents weekly to ensure that fingernails and toenails are clean and trimmed; and facilitate podiatry consults. The Nail Care Log was modified to note: • Date of exam by the Skin Integrity Resource RN or ADON (or designee). • Whether fingernails and toenails are neat and trimmed. • Completion of toe and/or nail care. • Scheduled for Pretty Nails with Activities (held twice monthly). • Referral to Podiatry Continued on page 15	09/20/11 09/19/11 09/19/11

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F 312	Continued From page 14 list to document the residents name and when their finger nails were last trimmed or filed. The ADON #1 further stated she expected the NAs to clean under residents finger nails during showers and as needed. The ADON #1 indicated the activity therapist also scheduled finger nail filing/painting once or twice a month. On 08/25/11 at 2:40 PM the ADON #1 observed Resident #8's finger nails and agreed they were too long and needed to be filed. On 08/25/11 at 3:38 PM NA #1 reviewed her nail care list and confirmed Resident #8's finger nails were last filed on 08/02/11. 2. Resident #20 was admitted on 03/16/11 with diagnoses including Dementia and Diabetes Mellitus. A significant change minimum data set (MDS) dated 06/28/11 revealed Resident #20 had severely impaired cognition and was usually understood. The significant change MDS indicated Resident #20 required extensive assistance personal hygiene and was totally dependent on staff for bathing. In addition, the significant change MDS noted that rejection of care was not exhibited. A care plan dated 03/21/11 identified Resident #20 as at risk for a self care deficit due to cognitive impairment and impaired mobility. Interventions included: "Keep/Assist resident to keep hair and nails clean and well groomed." Observations of Resident #20's finger nails on 08/22/11 at 12:36 PM revealed all ten (10) finger nails extended approximately 1/8 of an inch beyond his finger tips with black debris noted under the right thumb nail. On 08/23/11 at 8:34	F 312	F 312 continued...... Monitoring Process. The Nail Care Log will be reviewed monthly by the ADON or designee. Percentage of compliance to weekly assessment of Nail Care will be calculated. Benchmark of 95% completion has been set. These findings and any variances will be reported to the Performance Improvement Committee during the 4th quarter Quality Improvement Meeting in January 2012. The outcomes of the study will be discussed to determine the need to re-evaluate current processes and the time-frame to continue monitoring.	09/22/11

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F 312	Continued From page 15 AM Resident #20's finger nails extended approximately 1/8 of an inch beyond his finger tips with black debris noted under the right thumb nail. An additional observation on 08/24/11 at 8:30 AM revealed Resident #20's finger nails extended approximately 1/8 of an inch beyond his finger tips and his right thumb was not visible. An interview with nursing assistant (NA) #4 on 08/25/11 at 9:30 AM revealed NAs were not allowed to trim finger nails of Diabetic residents and she informed the nurse when a Diabetic resident had nails in need of a trimming. During an interview on 08/25/11 at 9:35 AM Licensed Practical Nurse (LPN) #3 stated NA #1 (Restorative Nursing) monitored and provided nail care to residents'. An interview was conducted with the Assistant Director of Nursing (ADON) #1 on 08/25/11 at 2:10 PM. The ADON #1 stated NA #1 filed Diabetic residents' finger nails and maintained a list to document the residents name and when their finger nails were last trimmed or filed. The ADON #1 further stated she expected the NAs to clean under residents finger nails during showers and as needed. The ADON #1 reviewed the NAs assignments and confirmed Resident #20 had been showered on 08/24/11. At the completion of the interview at 2:15 PM, ADON #1 observed Resident #20s finger nails and agreed they needed to be filed and cleaned. On 08/25/11 at 3:38 PM NA #1 reviewed her nail care list and confirmed Resident #20's finger nails were last filed on 07/17/11.	F 312		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 16 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to monitor behaviors related to the use of a anti-anxiety medication for one (1) of ten (10) sampled residents. (Resident #39) The findings are:	F 329	F 329 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The behavioral indications for administration of Ativan therapy for the identified resident were confirmed by the attending physician . According to current policy on Psychotropic Drug Management — "When psychotropic medications are being used to manage behavior, the licensed nurse monitors for and documents q shift , the presence or absence of the specific behaviors on the Medication Administration Record". These behaviors were placed on the MAR for monitoring by the licensed nurse according to policy. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. All current residents receiving anti-anxiety medication will be identified by pharmacy services. MARS will be reviewed for these residents to ensure that behavioral indications are transcribed for monitoring by nursing on each resident's MAR. Continued on page 18	08/24/11 08/24/11 09/22/11 09/22/11

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Resident #39 was admitted to the facility 6/6/09 with diagnoses of Thyroid Disorder, Depression, Cancer, Coronary Artery Disease, Hypertension and Renal Insufficiency. Review of the most recent Minimum Data Set (MDS), dated 5/15/11, indicated she was alert, oriented and able to be interviewed. The MDS also indicated she required extensive assistance with all activities of daily living.

Review of the physician's orders revealed the resident received Ativan .5 milligrams (mg) three (3) times per day for Anxiety and to hold the medication if the resident was not anxious. Review of the nurse's notes revealed the resident often expressed anxiety regarding her sibling, who also resided in the facility According to the nurse's notes, the resident expressed concern and/or anxiety regarding her sibling on the following dates:

7/12/11 Resident asked numerous times if her sibling was leaving the facility and wanted to speak to her on the phone.

7/15/11 Resident expressing concern about her sibling going away.

7/18/11 Resident anxious and paranoid and insisted her sibling was being transferred. Resident was in the hall shouting staff lied to her and she knew her sibling was leaving. During a second incident on 7/18/11 the resident was anxious again about her sibling leaving.

7/20/11 Resident went to her sibling's room and began yelling about her leaving and staff had lied

F 329 F 329 continued.........

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

The pharmacist will check and provide follow-up to ensure that all new orders for anti-anxiety medications include behaviors to be monitored. These behaviors will be placed on the MAR to be monitored by nursing according to policy. 09/22/11

Review of the Psychotropic Drug Management policy will be presented at in-service training initiated on 09/12/11. 09/22/11

Clinical Orientation for all newly hired licensed nurses (initiated on 08/30/11) includes lecture and a computer based competency on the management of psychotropic medications.

Monitoring Process

The pharmacist will collect and aggregate data including: current and new residents receiving anti-anxiety medications and percentage of compliance to monitoring of behaviors on the MAR. These findings and any variances will be reported to the Performance Improvement Committee. Failure to follow expectations will result in re-evaluation of current processes and follow-up for involved licensed nurses.

09/22/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK HOSPITAL LTC	418 CHESTNUT ST BLOWING ROCK, NC 28605

(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 329	Continued From page 18 to her. The nurse documented, "Pt (patient) observed to be depressed, crying at times when she thought nobody was looking and easily annoyed with sibling." The note further documented Resident #39 was concerned she was not getting all of her medication as prescribed. 8/20/11 Resident was in her sibling's room and began to scream about her sibling's drink. Review on the Medication Administration Record (MAR) on 8/25/11, with Registered Nurse (RN) #1, revealed no behavior monitoring sheets for Resident #39. RN #1 stated at the time of the review, there were times when the resident had behaviors but there were no monitoring sheets. The MAR documented the resident had received Ativan three (3) times per day everyday of August 2011, except August 8 th. The MAR had a blank. RN #1 stated if the medication had not been given the blank should have been circled and an explanation given of the back. Review of the back of the MAR revealed no explanation for the blank. Review of the July 2011 medication and treatment records revealed no behavior monitoring for the use of Ativan for Resident #39. Interview with the Director of Nursing (DON) on 8/24/11 at 5:15 p.m. confirmed there were no behavior monitoring sheets related to the use of Ativan.	F 329		
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary	F 360		

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F 360

Continued From page 19
needs of each resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interview and staff interview, the facility failed to provide a diet free of food allergies to one (1) of one (1) sampled resident. Resident #66.

The findings are:

Resident #66 was admitted to the facility on 8/18/11. Review of the medical record revealed the following documents which noted tomatoes as a food allergy:
*Physician's Orders dated 8/18/11;
*Resident Admission Assessment by nursing dated 8/18/11;
*Diet Order Form dated 8/18/11; and
*History and Physical examination dated 8/20/11.

The Resident Admission Assessment dated 8/18/11 assessed Resident #66 as having no memory problems and being independent with decision making.

On 8/23/11at 5:25 p.m. Resident #66 was served dinner in her room. Her meal included a salad with tomatoes which she took off the salad. She stated that she had called staff and requested another salad with more cheese and bacon. She further stated she was allergic to tomatoes and if she ate them would end up in the emergency room with a swollen throat. She further stated she had received tomatoes on her trays before. The diet card which accompanied her tray noted

F 360 F 360

On 8/23/11 the Food Service Director met with the kitchen staff to discuss resident #66 and her allergy to fresh tomato products. Although the resident had completed a select menu and clearly circled items that were fresh tomatoes or that contained fresh tomatoes, the Food Service Director made it clear to the staff that resident #66 cannot receive fresh tomatoes or foods containing fresh tomatoes as she is allergic to these products. The Food Service Director wrote "DO NOT SEND FRESH TOMATOES OR FOODS CONTAINING FRESH TOMATOES" on the resident's select menu in bright orange. The Food Service Director highlighted this on the resident's tray card. — 08/23/11

The Food Service Director created Food Allergy Alert Stickers on 9/12/11 that will take the place of highlighting or documenting food allergies with markers on tray cards or select menus.
Any resident admitted to the facility with food allergies documented in the medical record will receive a Food Allergy Alert sticker on their tray cards and, if applicable an allergy sticker will be attached to the select menu.
A Food Allergy Check Sheet was created on 9/12/11 to be completed by the cook at each meal. The cook will be required to double check the tray of a resident with food allergies and complete the check sheet. — 09/12/11

ON 9/14/11 Clinical Director of Nutrition Registered Dietitian conducted an in-service meeting on Food Allergies and Intolerances. — 09/14/11
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F 360	Continued From page 20 in bold print and capital letters the allergy of nuts and tomatoes.	F 360	F 360 continued…..	
	On 8/23/11 at 5:34 p.m. the dietary manager brought another salad to Resident #66 per her previous request. The new salad also included tomato. The dietary manager stated that the kitchen staff had a lot of salads made up and just sent up the wrong salad for Resident #66. At this time, she clarified with Resident #66 that it was only the fresh tomatoes she was allergic to and not processed tomato products.		In addition to the Food Allergy Alert stickers and the Food Allergy Check Sheet the current Diet Order Form submitted from the Ward Secretaries will be altered. The section of the Diet Order Form pertaining to resident's food allergies will be formatted in bold red to stand out and alert the food service staff when printing the diet orders.	09/12/11
	On 8/23/11 at 5:45 p.m. the dietary manager stated that this past Monday (yesterday), the facility began offering a selective menu to a few residents. Resident #66 was one of them. The dietary manager explained and showed the surveyor the selective menu consisted of the weeks menu and alternates. Residents circled their preferences and the cook then read and followed this menu. The dietary manager stated that because the cook read from this menu, the allergies were not readily accessible to the cook. The dietary manager further noted that Resident #66 had circled salad and lettuce and tomato. The dietary Manger stated that the kitchen staff should not be sending foods to which residents are allergic even if they are circled.		An in-service meeting with the Nutrition Service staff was conducted on 9/14/2011 by the Food Service Director to discuss the residents with food allergies and the upcoming changes and/or processes put into place to prevent residents receiving foods which they are allergic to.	09/14/11
	On 8/24/11 at 12:12 p.m., Resident #66 stated she circled lettuce and tomato because they were on the same line together on the menu.		A Net Learning module will be created and added to employees "To Do List" on their required education. This Net Learning Module will be required to be completed by all newly hired staff and annually thereafter.	09/22/11
	8/25/11 at 10:10 a.m. Resident #66 again stated that she is allergic to fresh tomatoes, not processed or cooked ones. She stated she swelled and itched if she ate fresh tomatoes.			

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F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to follow the planned menu for the pureed diet, which affected fourteen (14) of fourteen (14) residents, who received a pureed diet. The findings include: Observation of the tray line service was observed on 8/25/11, beginning at 11:00 a.m., with the Certified Dietary Manager (CDM) present. The following concerns were identified: The planned menu indicated four (4) ounces of pureed broccoli should be served. The facility served three (3) ounces. At the time of the observation, Cook #1 stated he did not have a four (4) ounce scoop for the broccoli and was giving a little more. The planned menu indicated three (3) ounces of pureed pork tenderloin should be served. The facility served four (4) ounces. Cook #1 also stated, since he was not using a three (3) ounce scoop for the pureed meat, he was giving a little less.	F 363	F 363 Cook #1 was counseled by the Food Service Director on the importance of following the modified menus and the portions to meet the daily requirements of our residents. Cook #1 expressed that he was nervous while the inspector stood over him during the tray line process. The actual scoops were available he just had them in the wrong puree foods. In addition the gravy that was supposed to be served over the puree rice was on the burner behind the service area. The cooks were counseled on proper tray line set-up. When two or more cooks are involved they will meet prior to tray line service to discuss the menu for that meal, the set-up of the steam tables, and the location of food items. On 9/14/2010 the Registered Dietitian, Director of Clinical Nutrition conducted an in-service training on Portion Control with the Nutrition Service staff. The Nutrition Service Competency Fair for employees will include the topic of understanding modified menus and accuracy of portion sizes. A column will be added to the current temperature chart for the cook to check off that he or she is using the proper scoops or ladles. In addition the weekly test tray will be completed. This includes a section that checks to see correct portion sizes are being served. Continued on page 22 a	09/12/11 09/14/11 09/22/11 09/22/11

POC	Completion Date
Page 22 a	
F 363 continued......	
A column has been added to the current temperature chart for the cook to check off that he or she is using the proper scoops or ladles at each meal service.	
The CDM, RD, Food Service Manager, or cook will be present during the tray line process to ensure portion utensils are being used correctly. They will also conduct a weekly test tray summary which includes a section for checking portion sizes.	
A Performance Improvement indicator has been created to measure the portion size check-off list and the test tray summary.	09/22/11

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F 363 Continued From page 22

The planned menu indicated four (4) ounces of puree rice with gravy should be served. The facility did not serve any gravy with the puree rice.

F 364 SS=E 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observation, and resident interview, the facility failed to ensure food was served to residents at an acceptable temperature which had the potential to affect 53 of 55 residents who received yogurt as part of the observed meal.

The findings include:

Interview with six sampled interviewable resident revealed the following related to food palatability::
On 8/22/11, at 12:06 p.m. Resident #39 said, "It is touch and go. It is just not hot. It doesn't really matter which meal."
On 8/23/11 at 9:08 a.m., Resident #66 said, "The food is always cold." Resident #5 stated on 8/22/11 at 4:50 p.m. the coffee was always cold.
On 8/23/11, Resident #36 said, "On average the food is not hot."
On 8/23/11, at 11:11 a.m., Resident #10 said, "The coffee is always cold and the food is cold too."
On 8/22/11, at 4:02 p.m., Resident #13 stated the

F 363 F 364 F 364

On 8/25/2011 the test tray summary indicated that food temperatures were within range at the time of meal service. The surveyor indicated the test tray observation time was 1:35 p.m. when the actual observation time was 12:35 p.m. The cart was delivered to the floor at 12:15 p.m. and the test tray was not pulled until 12:35 p.m. which was twenty minutes after delivery to the floor.

On 9/12/2011 the Food Service Director met with the 2nd Floor Assistant Director of Nursing to discuss the timeliness of trays passed to residents once the food carts are delivered to the floors. It was determined that the current set-up was not efficient due to the mix of independent residents and dependent residents. In an effort to make the process more efficient and to ensure residents receive their trays while temperatures are within acceptable range, the food carts were reorganized. All independent residents will be separated from dependent residents. The independent residents will receive their trays first and the dependent residents thereafter. **This process included the 1st floor long term care residents.**

On 9/12/2011 the Food Service Director met with the Nutrition Service staff to discuss the process for coffee. Coffee will no longer be sent on resident trays in individual mugs. Carafes, coffee mugs, cream, and sugar will be placed on each food cart for service to the residents. The carafes will be filled with hot coffee 15 minutes prior to meal service. 09/12/11

Continued on page 23 a

POC	Completion Date
 F 364 continued......	
The residents that wish to receive coffee will be identified on their individual tray cards. In addition nursing staff will offer coffee to all residents.	
The CDM, RD, Food Service Manager, or cook will be present during the tray line process to ensure portion utensils are being used correctly. They will also conduct a weekly test tray summary. Temperatures are monitored on the test tray summary during preparation on meal trays and again during the passing of resident trays. (Please find a copy of the test tray summary enclosed in the PoC.)	09/12/11
Measures put into place or systemic changes made to ensure the deficient practice will not occur:	
On 9/12/2011 the set-up of the food carts was reorganized	
On 9.12/2011 coffee carafes replaced the use of individual mugs of coffee on resident trays	
On 9/12/2011 a Resident Quality of Life Survey was developed to include specific questions about resident satisfaction with food served.	
Questions on the survey related to food temperatures include: 1. How is the temperature of the food? 2. Are your beverages cold or hot enough?	09/12/11

Continued on page 23 b

FOOD AND NUTRITION SERVICES TEST TRAY EVALUATION **BLOWING ROCK HOSPITAL**

DATE:	DAY: S M T W T F S	MEAL: M N E	DIET	PATIENT UNIT:
COMPLETED BY:		ASSIGNED COOK AND TRAY AIDE		

INSTRUCTIONS:
1. Do not remove cover/lid(s) until ready to take temperature.
2. Take the temperature of each cold item on the tray first, followed by each hot menu item.
3. Insert digital thermometer into the center of each serving and hold until indicator comes to rest.
4. Write name of menu item in the menu item column.
5. Record temperature of each item as it is taken.
6. Score quality control factors & compute "total possible" and "total" points scored for each factor.
7. Add total points scored and total possible points for quality control factors and compute overall evaluation.
8. Notify CA of any immediate concerns for that meal delivery that would require reheating or substituting items on tray (i.e., poor temps, expired milks, etc)
9. Submit evaluation to Clinical Nutrition Manager.

1 = SATISFACTORY (Very Good, Good) **QUALITY CONTROL FACTORS** 0 = UNSATISFACTORY (Fair, Poor)

Temperature Range*	**Menu Item**	**Kitchen Temp**	**Point of Sev. Temp**	**Temp**	**Taste/ Aroma**	**Portion**	**Appearance**	**Score**	**Delivery & Overall Appearance**
Cold to touch	SALAD: (HOUSE OR TOSSED)								ACCURATE
>140°	SOUP:								ATTRACTIVE
≤ 45°	MILK: Exp.date:								CLEAN/DRY
≤ 55°	COLD ENTRÉE:								WELL ARRANGED
>140°	HOT ENTRÉE:								FOOD PREFERENCES MET
>140°	STARCH:								Other Comments:
>140°	VEGETABLE:								ARE ANY FOODS SERVED ON PAPER DISHES?
Satisfactory Unsatisfactory	BREAD:								COMMENTS:
≤ 55°	DESSERT:								
≤ 55°	COLD BEVERAGE:								
>140°	HOT BEVERAGE:								
	TOTAL POINTS SCORED								TOTAL OVERALL POINTS SCORED =
	TOTAL POSSIBLE POINTS								TOTAL OVERALL POSSIBLE POINTS SCORED =

TIMELINESS OF TRAY DELIVERY

A. TIME TRAY DELIVERED TO PATIENT:

B. TIME TRAYS LEAVE KITCHEN:

A – B=

OVERALL EVALUATION

- ☐ VERY GOOD (95 –100%)
- ☐ GOOD (90 – 94%)
- ☐ FAIR (85 – 89%)
- ☐ POOR (< 85%)

OVERALL EVALUATION SCORE

CORRECTIVE ACTION PLAN / COMMENTS:

Blowing Rock Hospital, LTC
418 Chestnut Drive
Blowing Rock, NC 28605

Provider ID # 345045

Survey Completion Date: 08/25/2011

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F 364 continued..........	
The facility plans to monitor its performance to make sure that solutions are sustained:	
Facility staff including the Certified Dietary Manager, Registered Dietitians, ADON's and their designees will conduct the Quality of Life surveys. Sample selection will include five residents starting in chronological order of room numbers on each floor. These residents will be given the survey weekly initiating the week of 09/19/11. This survey will be conducted through December 3, 2011. The ADON or designee will collect and aggregate survey data to determine need for re-evaluation of current processes and follow-up for involved staff. These findings and any variances will be reported to the Performance Improvement Committee during the 4th quarter Quality Improvement Meeting in January 2012. The outcomes of the study will be evaluated, and monitoring will be continued or discontinued based on committee recommendations.	
The Food Service Director or designee will collect data on test tray summaries which includes monitoring temperatures beginning the week of 09/19/2011. Test tray data and the findings and any variances will be reported to the Performance Improvement Committee during the 4th quarter Quality Improvement Meeting in January 2012. Immediate corrections will be made in processes if the weekly test tray summary or Quality of Life Surveys deem necessary.	09/22/11

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F 364	Continued From page 23 food was cold. Observation of regular, pureed, and mechanical soft test trays on 8/25/11, at 1:35 p.m. with the Certified Dietary Manager (CDM) revealed the following:. The coffee did not taste hot. The pureed pork tenderloin did not taste hot and the yogurt was not cold.	F 364	F 366 Address how corrective action will be accomplished for the resident found to have been affected by the deficient practice. Immediate feedback/follow-up was given to the involved CNA (completed 08/25/11) Dietary services noted "no squash" in list of resident preferences. The Registered Dietitian will continue to monitor resident food intake and weight and provide recommendations as indicated.	08/25/11
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to offer a substitute for a food item for one (1) of three (3) sampled residents who expressed a dislike. Resident #46. The findings are: Resident #46 was admitted to the facility on 8/20/08 and readmitted 3/1/11. Diagnoses included Diabetes, Parkinson's Disease, Alzheimer's Disease, anemia, vitamin D deficiency, and gastroesophageal reflux disease. Review of Resident #46's weight history revealed she weighed 139 pounds on 5/7/11 and 129 pounds on 8/7/11. The annual Minimum Data Set (MDS) dated 8/9/11 assessed Resident #46 with severe cognitive impairment. Resident #46 was	F 366	Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. An in-service presentation was developed for nursing staff to address survey deficiencies, provide education and brainstorm solutions for improvement in the facility. These sessions initiated on 09/12/2011 include education on: • Regulation 485.35—with resident scenario and discussion of facility expectations that the resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food. • Clinical Orientation for all newly hired licensed nurses (initiated on 8/30/11) includes lecture and a small group game session related to resident rights and dignity. Substitution for foods refused by the resident will be integrated into the presentation utilizing the resident scenario initiating on the next orientation held 9/20/11. Continued on page 25	09/22/11 09/20/11

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F 366	Continued From page 24 independent with eating after tray set up. The MDS also noted Resident #46 was 129 pounds and received a mechanically altered therapeutic diet. The Nutritional Comprehensive Area Assessment dated 8/12/11 noted Resident #46 continued to have gradual weight loss. The care plan for nutrition last updated 8/17/11 noted the problem of gradual unplanned with loss with a goal to prevent weight loss. Interventions included in cueing and reminding the resident to eat during meals. On 8/23/11 at 4:55 p.m. Nurse Aide #6 walked out with Resident #46 from her room into the main dining room. At 4:59 NA #6 served Resident #46 her meal tray which included pinto beans, cabbage and cooked squash. As NA #6 asked Resident #46 if she wanted butter on her squash, Resident #46 stated she did not like squash. NA#6 acknowledged the resident's statement and once the tray was set up left to assist other residents in the dining room with their meals. NA #6 made no attempt to obtain an alternative item for the squash. Resident began to feed herself independently. At 5:15 p.m. Resident #46 stood from table and left the dining room leaving the squash untouched. On 8/23/11 at 5:25 p.m. NA #6 was interviewed. NA #6 confirmed Resident #46 stated she did not like squash. NA #6 stated that sometimes they do offer alternatives but did not say why she did not get something else for Resident #46 when she knew the resident disliked squash.	F 366	F 366 continued…… <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</u> A Resident Quality of Life Survey was developed to include specific questions about resident satisfaction with foods served. Questions on the survey related to food preferences include: • If you dislike a food, does staff offer you a substitute? • Did you receive the items you ordered? (select menu) • Would you like to make any changes to your food preferences? Residents who are not able to participate in the Quality of Life Survey were identified. Cue cards were designed to assist the CNA to monitor these residents food preferences and intake changes. Key components include: • Identification of foods not eaten • Change in Appetite • Beverage of Choice • Comments Cue cards will be reviewed by the Certified Dietary Manager or Registered Dietitian weekly for patterns and trends. As a result of this information, the dietitian may as needed modify resident preferences, monitor resident food intake or weight and make recommendations if appropriate. Continued on page 25 a	09/22/11 09/20/11 09/22/11

Department of Health and Human Services / Centers for Medicare & Medicaid Services

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Monitoring Process.	
For Quality of Life Survey Participants Facility staff including the Certified Dietary Manager, Registered Dietitians, ADON's and their designees will conduct the Quality of Life surveys. Sample selection will include five residents starting in chronological order of room numbers on each floor. These residents will be given the survey weekly - initiating the week of 09/19/11. This survey will be conducted through December 31, 2011.	09/22/11
For Residents Unable to Participate in the Quality of Life Survey Random weekly observations by nursing leadership and/or the Certified Dietary Manager will be initiated on 09/22/11. The sample group will include residents being assisted with eating in the dining area and residents' room. Compliance to noting and reporting key components of the cue cards will be measured.	09/22/11
For Both Monitoring Methods The ADON or designee will collect and aggregate survey data to determine need for re-evaluation of current processes and follow-up for involved staff. These findings and any variances will be reported to the Performance Improvement Committee during the 4th quarter Quality Improvement Meeting in January 2012. The outcomes of the study will be evaluated, and monitoring will be continued or discontinued based on committee recommendations.	09/22/11