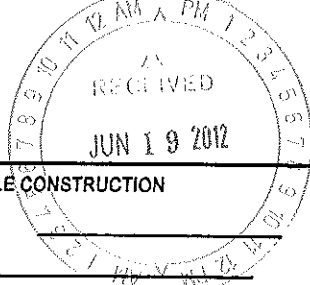


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to develop a plan of care for pressure ulcers for 1 (resident #10) of 4 sampled residents with pressure ulcers and the facility failed to develop a plan of care for</p>	F 278	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.</p> <p>F278</p> <p><u>Corrective Action – affected resident(s)</u></p> <p>The care plan for resident #10 was developed 5/17/12 to include a problem related to her pressure ulcer and risk for further breaks in skin integrity. (Attachment #1) After review it was determined the listed findings are actually for resident #85 who expired in our facility 3/10/12 as a result of metastatic brain cancer.</p> <p><u>Corrective Action – potential resident(s)</u></p> <p>Facility has recently hired a new MDS /Care Plan Coordinator in part due to concerns with care plan accuracy. All care plans are currently in the process of being updated. We have completed updates to care plans for all current residents with impaired skin integrity, weight loss and nutritional concerns (Attachment 16A-T) (con't)</p>	06/07/2012
---------------	---	-------	--	------------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE RN / CNHA	(X6) DATE 6/7/12
---	--------------------	---------------------

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.

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 278	<p>Continued From page 1</p> <p>weight loss for 1 (Resident #56) of 3 sampled residents with nutritional concerns and weight loss.</p> <p>Findings include:</p> <p>1) Resident #10 was admitted to the facility on 11/11/11 with a diagnosis of Traumatic Hip Fracture.</p> <p>Review of the resident ' s most recent care plan dated 11/14/11 revealed no problems identified for a pressure ulcer.</p> <p>Review of the resident ' s medical record revealed the resident had a Stage IV pressure ulcer to her right hip that measured as 9 cm (centimeters) by 5 cm by 3 cm deep.</p> <p>During an interview with the Charge Nurse on 5/17/12 at 10:54 AM, the nurse revealed the resident ' s wound was identified as having occurred in the facility and the date of origin was unknown</p> <p>During an interview with the MDS (Minimum Data Set) Nurse on 5/17/12 at 11:44 PM, the nurse reported the care plan hadn't been updated since November 2011 and should have been. The MDS nurse stated the resident ' s wound was not addressed on the care plan and should have been.</p> <p>During an interview with the Director of Nursing (DON) and Administrator on 5/17/12 at 12:10 PM, the DON and Administrator reported they became aware they had problems with the care plans in the facility and problems that were not</p>	F 278	<p>F278 (con't)</p> <p><u>Systemic Changes to prevent recurrence</u></p> <p>Nurse management and IDCP team received training by Corporate QA Nurse Consultant 6/6-7/12 on updating care plans as a part of Liberty Healthcare's new Daily Quality of Life processes (Attachment #2). MDS / Care Plan Coordinator will attend daily Quality of Life Meeting and bring all current care plans. Any issues discussed during the meeting which impact plan of care will result in immediate update of the care plan. Additionally, care plans will be reviewed and updated as indicated with completion of each scheduled MDS with residents and families being invited to attend care plan review within one week of MDS ARD.</p> <p><u>Evaluation of Plan / Monitoring</u></p> <p>As a part of Liberty Healthcare's revised Quality of Life program, the Interdisciplinary Care Planning Team will review all in-house pressure ulcers using the "Weekly Pressure Ulcer" monitoring tool (Attachment #3) which includes the audit of "Care plan current with all current wounds?" weekly. Findings will be discussed during Weekly Quality of Life meeting.</p> <p>The "Weekly Weight" audit sheet (Attachment #4) will be completed for all residents on weekly weights and/or experiencing current weight loss with findings presented at the Weekly Quality of Live meeting. Audit includes review item of "Care Plan Updated" for weight loss.</p>	
-------	---	-------	--	--

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	Continued From page 2 care planned. The DON stated Resident #10 should have had a care plan for the wound. 2. Resident #56 was admitted to the facility on 1/23/12 with a diagnosis of Neoplasm (a form of cancer), Hypertension, and Decubitus Ulcer. Record review on 5/16/12 revealed an admission weight on 1/23/12 of 147 pounds On 2/7/12 the resident weighed 138 pounds. The nutritionist noted he had lost 9.5 pounds since 1/23/12 in the progress notes. He was started on a med pass nutritional supplement on 2/24/12 at which time and was also receiving a multivitamin and a bedtime snack. Further record review indicated the resident weighed 135 pounds on 3/4/12. On 3/9/12 the nutritionist noted the resident needed assistance with feeding. He was started on a protein nutritional supplement 30 milliliters (ml) each day. Review, during the survey, of the resident 's most recent care plan dated 1/29/12 revealed no care plan was developed for prevention of weight loss. An interview with the Administrator on 5/17/12 at 11:05 AM revealed she expected care plans reflected current concerns of weight changes and nutrition concerns.	F 278	These audits will be done weekly for 3 months or until resolved by the QOL/QA committee. Reports will be given to the weekly Quality of Life/QA committee and corrective action initiated as appropriate.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280			

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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 280	<p>Continued From page 3</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to update a care plan after removal of an indwelling urinary catheter for 1 (Resident #88) of 4 sampled residents with indwelling urinary catheters.</p> <p>The resident was admitted to the facility on 3-7-12 and discharged 4-27-12. A hospital discharge summary dated 3/7/12 revealed diagnoses of UTI and Urinary Retention for Resident #88.</p> <p>Review of the Hospital Course revealed the resident had recurrent urinary tract infections and urinary retention. The resident was discharged to the facility to complete a course of Levaquin</p>	F 280	<p>F280 <u>Corrective Action – affected resident(s)</u></p> <p>Resident #88 was discharged 4/27/12</p> <p><u>Corrective Action – potential resident(s)</u></p> <p>Nurse management team reviewed all current residents with indwelling catheters. MDS / Care Plan Coordinator reviewed all care plans to assure each current resident has an updated care plan addressing concerns related to indwelling catheter use. (Attachment #5 A-D)</p> <p><u>Systemic Changes to prevent recurrence</u></p> <p>As part of facility's revised Daily Quality of Life program, the nurse management team will review all physician orders written/received since the previous meeting. Any changes in care or clinical condition noted on orders will be reviewed and addressed on the residents care plan. Updates to care plan will be noted on "Change of Clinical Condition" form and presented at Weekly Quality of Life meeting by MDS / Care Plan Coordinator. (Attachment 6)</p> <p><u>Evaluation of Plan / Monitoring</u></p> <p>Nurse management team will complete the "Weekly Clinical QA Meeting Checklist" (Attachment #7) weekly to review all "Care Concern Areas" which include Indwelling Catheters. MDS / Care Plan Coordinator will verify at that time there is a current and updated care plan for all Care Concern Areas including indwelling catheters.</p>	06/06/12

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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 280	<p>Continued From page 4 (antibiotic). Recommendations from the hospital included: Continue the (indwelling urinary catheter) for now. Schedule an appointment with (name of Urologist) for urology evaluation for recurrent urinary tract infections, hematuria (blood in urine), and retention.</p> <p>The resident ' s medical record revealed a Urology Consultation Report dated 3/14/12 for Hospital follow up. Findings were documented as urinary retention New Physician's orders per the consultation were documented as: leave (indwelling urinary catheter) in, routine catheter care, bladder rehabilitation, clamp the catheter for 4 hours and release for 1 hour.</p> <p>An additional Urology Consultation Report dated 4/11/12 revealed a diagnosis of urinary retention and new physician's orders were documented as: removed catheter today, re-insert if unable to urinate, and to discontinue antibiotics.</p> <p>Review of the resident ' s care plan, dated 3/7/12, revealed a problem identified as "I use indwelling catheter due to my (diagnosis) of urinary retention with incomplete bladder emptying".</p> <p>During an interview with the MDS (Minimum Data Set) Nurse on 5/16/12 at 11:25 AM, the nurse stated the care plan should have been updated within 24 to 48 hours after the catheter was discontinued because staff needed to monitor the resident for retention or infection.</p> <p>During an interview with the Director of Nursing (DON) on 5/17/12 at 12:10 PM, the DON and reported she was aware there were problems with the care plans in the facility and problems</p>	F 280	<p>These audits will be done weekly for 3 months or until resolved by the QOL/QA committee. Reports will be given to the weekly Quality of Life/QA committee and corrective action initiated as appropriate.</p>	

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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 280	Continued From page 5 that were not care planned. The DON stated the change for Resident #88 should have been updated on the care plan.	F 280	F314	06/06/2012
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide a pressure relieving cushion in a chair for 1 (resident #68) of 4 sampled residents with pressure ulcers and at risk for further pressure ulcers. Findings include: The resident was re-admitted to the facility on 3/26/12 with diagnoses to include a hip fracture without repair, pressure ulcer of the lower back, pressure ulcer stage II, and pressure ulcer of the heel. Review of the resident 's most recent Minimum Data Set, an annual assessment of 4-16-12, revealed Resident #68 required extensive assistance of two or more staff for bed mobility	F 314	<p><u>Corrective Action – affected resident(s)</u></p> <p>A pressure relief cushion was placed in resident #68's geri-chair 5/16/12. After discussion of pressure relief in geri-chairs by nurse management team, it was determined our facility would order 2 "Geo-wave" cushions made specifically for geri-chairs. (Attachment #8). Once received, a Geo-wave will be placed in resident #68's geri-chair to replace current pressure reduction cushion.</p> <p><u>Corrective Actlon – potential resident(s)</u></p> <p>During facility's Weekly Quality of Life Meeting 6/6/12, all current residents with pressure-related skin breakdown were reviewed to assure each had current orders for pressure reduction devices both in bed and in chair while out of bed appropriate to the seating surface. It was also verified that the ordered pressure-reduction devices were in place. (Attachment #3)</p> <p><u>Systemic Changes to prevent recurrence</u></p> <p>Each day the nurse management team will review any pressure ulcer noted since prior Daily Quality of Life clinical meeting using the "New Pressure Ulcers" audit sheet (Attachment #9). One item on the audit states "Have support surfaces such as low air loss mattress and chair pressure reduction cushions been implemented?" (con't)</p>	

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

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983		
(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 314	<p>Continued From page 6</p> <p>and toileting. The resident was documented as required total assistance of two or more staff for transfers. The resident was documented as cognitively impaired. The assessment revealed the resident was at risk for pressure ulcers and had an unhealed Stage IV pressure ulcer that was not present for the prior assessment of 1/16/12. Active diagnoses included a hip fracture.</p> <p>Review of the most recent care plan dated 5/14/12 revealed a problems identified as "I have a stage IV pressure ulcer to my right hip and am risk for complications related to same ". Interventions were documented in part as: Chair cushion in place while up in w/c. An additional problem identified on the resident ' s care plan included " I have skin breakdown and am risk for further breakdown (related to) impaired mobility and Incontinence ". Since the resident ' s hip fracture and return to the facility without repair on 3/26/12, the resident has been in a Geri-chair rather than the wheelchair to decrease his pulling on the joint during locomotion in a wheelchair.</p> <p>Review of a facility " Weekly Wound Review " of 4/24/12 revealed a wound that developed on the resident's sacrum as an in-house wound, a Stage II pressure Ulcer that measured 1.0 cm (centimeters) by 1.0 cm by 0.2 cm deep. Weekly measurements continued. The Weekly Wound Review of 5/8/12 documented the wound as: right buttocks Stage I that measured 1.8 cm by 0.5 cm, and left buttocks Stage I that measured 1.5 cm by 1.2 cm. During an interview with the Charge Nurse on 5/16/12 at 3:17 PM, the nurse reported the area on the resident ' s sacrum had healed in the middle and became left and right</p>	F 314	<p>F314 (Con't)</p> <p><u>Evaluation of Plan / Monitoring</u></p> <p>Each week during the facility's Weekly Quality of Life meeting the Interdisciplinary Care Planning Team will review all current residents with pressure-related skin breakdown to assure all indicated care measures are in place including "Pressure reduction mattress / chair cushion" using the "Weekly Pressure Ulcer" monitor (Attachment #3)</p> <p>These audits will be done weekly for 3 months or until resolved by the QOL/QA committee. Reports will begiven to the weekly Quality of Life/QA committee and corrective action initiated as appropriate.</p>		

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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 314	<p>Continued From page 7 buttocks wounds.</p> <p>During an observation of the resident on 5/16/12 at 10:10 AM revealed the resident in his room reclined in a Geri-chair with no cushion. An additional observation of the resident was made on 5/16/12 at 10:55 AM and revealed no seat cushion had been placed on the resident ' s chair. The resident did not make significant changes in position while in the Geri-chair during the observations.</p> <p>During an interview with Nursing Assistant (NA) #1 on 5/16/12 at 10:20 AM, the NA reported the resident used to have a cushion in his wheelchair but they didn't use a cushion while he has been in the Geri chair. The NA stated she would find out if he should have one while he was seated in the Geri-chair</p> <p>During an interview on 5/16/12 at 10:44 AM with Nurse #2 who worked regularly with the resident, the nurse reported the resident has been in the Geri-chair for about the past 3 weeks since breaking his hip. The nurse stated she did not remember the resident having had a cushion in the Geri-chair, but it made sense that he should have had one.</p> <p>During an interview with the Director of Nursing (DON) on 5/17/12 at 12:10 PM, the DON stated the resident should have had a chair cushion in the Geri-chair.</p>	F 314		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any</p>	F 329		

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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	<p>Continued From page 8</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interviews and record reviews the facility failed to monitor behaviors and side effects of antipsychotic medication +and conduct Abnormal Involuntary Movement Scale (AIMS) assessments for 1 of 2 sampled Residents (Resident #56) receiving psychoactive medications.</p> <p>Findings Include: Resident #56 was admitted to the facility on 6/24/11 with diagnoses of dementia, obsessive</p>	F 329	<p>F329</p> <p><u>Corrective Action – affected resident(s)</u></p> <p>AIMS was completed on resident #56 on 5/23/12 with no findings of Tardive Dyskinesia. (Attachment #10). New Monthly Flow Record of Behaviors was initiated for resident #56 on 06/01/2012. (Attachment #11 A-C) When Behavior Flow Record was reviewed 6/4/12 physician was notified of absence of behaviors and order was received to decrease dosage of Trazadone. (Attachment #12)</p> <p><u>Corrective Action – potential resident(s)</u></p> <p>AIMS assessments were completed on all current residents receiving psychoactive medications on 5/23/12. (Attachment #13). New Monthly Flow Record of Behaviors were initiated by placing in MAR binders with MAR's for all residents receiving psychoactive medications for behaviors on 6/1/12. (Attachment #14) Current psychoactive medications were reviewed by Interdisciplinary Care Planning Team during Weekly Quality of Life meeting on 6/6/12. No residents were indicated for dose reduction or discontinuance at this time related to ongoing behaviors and absence of tardive dyskinesia symptoms. (Con't)</p>	06/06/12
-------	---	-------	---	----------

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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	<p>Continued From page 9</p> <p>compulsive disorder, and obsessive compulsive personality disorder. The Minimum Data Sets (MDS) dated 6/30/11 and 3/26/11 indicated Resident #56 had behaviors that were verbal towards others for the past 1 to 3 days. The care area assessment dated 6/30/11 indicated he would yell out for cigarettes and demand to be taken to the smoking area without cigarettes. This behavior concern was to be included in the care plan. The care plan indicated Resident #56 would display verbally aggressive behaviors when demanding cigarettes from other residents, visitors and staff members. One of the approaches to this behavior was to monitor and document the behaviors of Resident #56.</p> <p>A record review of the facility physician orders revealed Resident #56 had started the medication Haldol (antipsychotic) 2 milligrams (mg) as needed on 6/27/11. This medication had been documented as given on the Medication Administration Record (MAR) to Resident#56 at times. The Haldol was discontinued on 4/30/12. The medication Risperdal (antipsychotic medication) at 2 mg was ordered on 6/27/11. The Risperdal was continued at a final decreased dosage of 0.5 mg daily. Resident #56 also received the medications of Klonopin (anti-anxiety medication) 0.5 mg three times daily and Trazadone (anti-depressant) 100 mg daily.</p> <p>A record review of the facility Psychoactive Medication Monthly Flow Record and Target Behavioral Symptoms forms was conducted. There was no documentation of behaviors for the following months: June 2011, July 2011, August 2011, September 2011, January 2012, February 2012 and May 2012.</p>	F 329	<p>F329 (Con't)</p> <p><u>Systemic Changes to prevent recurrence</u></p> <p>MDS Coordinator will complete AIMS on all residents receiving psychoactive medications with their quarterly MDS assessments or when indicated due to dose change, new order or discontinuance per policy.</p> <p>Nurse management team will be responsible for placing Behavior Monthly Flow Records in MAR binders at the beginning of each month and with new behaviors or psychoactive drug orders.</p> <p><u>Evaluation of Plan / Monitoring</u></p> <p>MDS Coordinator will bring copy of summary of completed AIMS to Monthly Quality of Life meeting for review to assure all residents receiving psychoactive medications have a current AIMS completed per protocol.</p> <p>Behavior Monthly Flow Records will be reviewed for all residents receiving psychoactive medications as a part of the facility's Monthly Quality of Life meeting. Any resident without documented behaviors or rare occurrences of behaviors will be referred to their physician for possible dose reduction or medication discontinuance. Pharmacy consultant will continue to monitor psychoactive drug use and Monthly Behavior Monthly Flow Sheets and make recommendations as indicated for dose reduction or discontinuance. Noted Behaviors will be discussed in Daily Quality of Life Meeting by nurse (con't)</p>	

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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	<p>Continued From page 10</p> <p>An interview with Unit Nurse Manager on 5/16/12 at 2:05 PM revealed behavioral monitoring sheets were kept in the MAR. The Nurse reported she started an audit tool for antipsychotic review last month. She documented resident behaviors from the behavioral sheets on each resident. She then gave a copy to the physician and pharmacist to determine if a gradual dose reduction was needed. The Unit Manager stated there should have been behavioral sheets in the MAR for May 2012.</p> <p>A record review of the facility AIMS form revealed there was one assessment conducted for Resident #56 on 10/11/11.</p> <p>An interview with the Administrator on 5/16/12 at 3:16 PM revealed that the AIMS assessments were one of the few things that were not being done regularly. The Pharmacist usually identified who needed an AIMS assessment. The MDS Nurse was then notified to conduct the assessment. The AIMS assessments were done when there would be a change in antipsychotic medication dosage, new antipsychotic medications implemented.</p> <p>A record review of the facility Psychotropic Drug Policy revealed an AIMS assessment assessed the existence and severity of movement side effects associated with antipsychotic medications. The AIMS assessment was completed when an antipsychotic agent was first started and at least every three months.</p> <p>An interview with the Pharmacist on 5/16/12 at</p>	F 329	<p>F329 (Con't)</p> <p>management team using "Behavior or Antipsychotic Medication Review" audit sheet and referred to physician for appropriate action.(Attachment #15)</p> <p>These audits will be done weekly for 3 months or until resolved by the QOL/QA committee. Reports will be given to the weekly Quality of Life/QA committee and corrective action initiated as appropriate.</p>	
-------	--	-------	---	--

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

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983
---	--

(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	<p>Continued From page 11</p> <p>3:37 PM revealed she requested AIMS assessments to be conducted on residents as a general protocol. She recommended an AIMS assessment be completed every three months for residents that were stable on an antipsychotic. She also recommended to conduct an AIMS assessment for the start of an antipsychotic medication, the discontinuing of an antipsychotic medication or dosage change of an antipsychotic. Her monthly report was provided to the Administrator and Director of Nursing (DON).</p> <p>An interview with the Administrator and DON on 5/17/12 at 10:28 PM revealed they expected the behavioral forms and AIMS assessments were conducted regularly on residents.</p>	F 329		

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

PRINTED: 06/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	RECEIVED JUN 11 2012 06/30/2012	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DR WINDSOR, NC 27983		

(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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, and is equipped with an automatic sprinkler system.	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.	
K 038 SS=D	CFR#: 42 CFR 483.70 (a) 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: Based on the observations and staff interview during the tour on 5/30/2012 the following item was observed as noncompliant, specific findings include: The door hardware leading from the soiled side of the laundry did not have pass through hardware installed resulting in more than one motion of the hand to exit from that space. CFR#: 42 CFR 483.70 (a)	K 038	<u>Corrective Action</u> Door hardware for laundry room door was replaced 5/18/2012 with a commercial grade single action lever handle. <u>Identifying Further Potential Effects and Correction</u> Plant Operations Manager and Administrator did a walk through of entire facility and assured all doors can be opened with single action motion <u>Systemic Changes</u> Any replacement door hardware will be reviewed by Safety Committee to assure it meets single action requirement for exit. <u>Monitoring</u> Plant Operations manager will complete walk through of facility each month prior to Monthly Quality of Life Meeting and assure all door hardware is single action. Report will be given during Monthly Quality of Life for review.	06/08/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Lynne Furlough / Victoria Barron TITLE *Business Office Manager* (X6) DATE *6/3/12*

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.