STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING _____ B. WING _____	11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK RD FAIRVIEW, NC 28730

(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 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide adequate lighting for 1 of 15 residents interviewed (Resident #118) regarding their environment. The findings are: Resident #118 was admitted to the facility on 10/23/2012. The comprehensive Minimum Data Set (MDS) dated 10/30/2012 indicated Resident #118 was able to see fine detail, including regular print in books. The MDS also indicated the resident was cognitively intact and it was very important to her that she be able to do her favorite activities. On 11/14/2012 at 10:48 AM, Resident #118 was interviewed about her environment and activities that she enjoyed. The resident had a book on her over-bed table and indicated she liked to read but that the light in her room wasn't adequate. Resident #118 indicated she didn't have much natural light because her roommate, who was by the window, preferred to keep the privacy curtain drawn. The resident indicated that one day she had tried to read in the hallway and told a nurse that she didn't have enough light. The resident could not remember which nurse she had told about the inadequate light in her room but said, "I've asked for a different room so I can be by the window."	F 256	The two 34 watt flourescent bulbs were replaced by maintenance the following morning with two 40 watt flourescent bulbs. (This is about equal to two 150 watt incandescent bulbs). The Social Worker and Administrator went to the room and checked that the lighting was brighter but resident was not in the room at the time to ask about it. Surveyor then stated that the new bulbs were not bright enough. I then placed a lamp on the bedside table and resident stated this was good. She has been moved to a window bed that became available as well. Activity Director interviewed all current oriented residents regarding the lighting. Lamps were provided to those residents who requested extra lighting. A question regarding adequate lighting has been added to the Activity Assessment which is done within the first week of admission. It states "Is the lighting in your room adequate for the activities you like to do?" If not activities will report to Administrator and the issue will be corrected. This will ensure that it does not occur again.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheri T. Mitchell — TITLE: Admin — (X6) DATE: 12/7/12

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.

DHSR NH LSC Black Mountain WRO Received DEC 14 2012 by: MMH

DHSR NH LSC Black Mountain WRO Received DEC 17 2012 by: SKH

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F 256	Continued From page 1 On 11/14/2012 at 4:05 PM, the Social Worker indicated she was aware that Resident #118 was waiting for a room by the window but didn't know the light in the room was not adequate for reading. The Social Worker said the person responsible for maintenance had left for the day but she would pass the information on to him the next day. The Social Worker did not talk to Resident #118 about the light in her room. On 11/15/2012 at 3:15 PM, Resident #118 was observed in her room. The privacy curtain was drawn which blocked much of the natural light. The only light on Resident #118's side of the room was a 34 Watt light which was approximately 3-4 feet above the resident's bed. The resident said she thought the maintenance man had changed the light bulb over her bed that morning but it wasn't any brighter. She also indicated that no one had been back to ask if the lighting was adequate. During an interview on 11/15/2012 at 3:20 PM, the Director of Maintenance indicated he had put in two new 34 Watt bulbs in Resident #118's room. The Director of Maintenance said, "But it didn't seem to make much difference. I don't know what else to do." When told the resident wanted to be able to read he said, "Well, I guess I could have someone come and change out the ballast [the ballast is a magnetic coil that adjusts the current through the tube] but that probably won't make it any brighter." On 11/15/2012 at 3:38 PM the Administrator was interviewed about the lighting in Resident #118's room. The Administrator said, "The first we	F 256	QA Coordinator will ensure monitoring of all new residents monthly to ensure that this issue has been addressed and document this action.	12/14/12

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F 256	Continued From page 2 heard about it was yesterday and [Maintenance Director] went in this morning and changed out the light bulbs." She indicated no one else had ever complained about it but that some residents would have family bring in a lamp. The Administrator added, "I don't know what else we can do." When told the resident wanted to be able to read and no one had checked to see if the light was adequate, the Administrator said, "I guess the only thing I can do is go out and buy a lamp."	F 256		
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, staff interviews, and medical record review, the facility failed to remove facial hair for 1 of 2 residents (Resident #86) requiring extensive or total assistance for activities of daily living. The findings are: Resident #86 was readmitted to the facility on 10/27/2012. The comprehensive Minimum Data Set dated 11/3/2012, indicated the resident was severely cognitively impaired and required extensive assistance for personal hygiene. The MDS did not indicate the resident resisted care. On 11/13/12 at 3:15 PM Resident # 86 was observed to have 10-12 white facial hairs that were approximately one-fourth to three-fourths of	F 312	The affected resident's facial hair was shaved immediately. Assigned nursing staff checked all other female residents and found no others with facial hair. Shower team was in-serviced on the grooming of female residents including shaving facial hair. It was also added more specifically to their job description "Shaving-Male and Female" during their weekly baths or showers. QA Coordinator will ensure weekly monitoring of at least 10 different female residents to check for facial hair and document. If any are found in need of shaving they will be asked if they would like to be shaved and if so will be shaved immediately by the nursing staff and documentation made. The QA committee will review documentation monthly to evaluate effectiveness and modify plan if needed. This will continue until full compliance maintained. The QA committee has developed a Quarterly Checklist which includes grooming and	

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F 312	Continued From page 3 an inch long over her chin area. Resident #86 had the same facial hairs present on 11/15/12 at 11:34 AM and on 11/16/12 at 8:44 AM. On 11/16/12 at 8:49 AM an interview was conducted with a family member of Resident #86 about the facial hair. The family member stated, "When she could see them she would take them off or we took them off for her. She would like them off, I'm sure." During an interview on 11/16 at 9:15 AM, Nursing Aide (NA) #1 indicated that either the NAs or the bath aides were responsible for removing residents' facial hair weekly during baths/showers and daily with ADL care as needed. The NA indicated that Resident #86 had been bathed earlier in the week but he had provided morning care on 11/15/2012. NA #1 said, "I guess I have to be more observant about that because women do have chin hairs just like men." During an interview on 11/16/ at 9:25 AM, the Director of Nursing (DON) stated NAs or Bath Aides were expected to remove residents' facial hair during baths/showers and daily with ADL care as needed. On 11/16/12 at 10:00 AM NA #2 indicated she had bathed Resident #86 on Tuesday, 11/13/2012. NA #2 indicated she had not noticed the facial hair that day.	F 312	specifically female shaving which will be completed by assigned staff and maintained to ensure that correction is sustained.	12/14/12
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase	F 318		

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F 318	Continued From page 4 range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to apply a hand splint to prevent contracture for 1 of 1 resident reviewed for range of motion (Resident #25). The findings are: Resident #25 was admitted with diagnoses including cerebral vascular accident (CVA) with left hemiplegia, arthritis, and osteoporosis. A quarterly Minimum Data Set (MDS) completed 08/16/12 revealed Resident #25 was cognitively intact, required limited assistance with eating, and extensive assistance with dressing, personal hygiene, and toilet use. The quarterly MDS noted limited range of motion that impaired function of her upper and lower extremity on one side. Review of an Occupational Therapy (OT) progress note dated 12/08/11 revealed Resident #25 was referred for services due to increasing tone and pain in her left hand with her thumb positioning into the palm of her hand. The progress note stated Resident #25 was at increased risk for skin breakdown and fixed contracture. OT skilled services were recommended at that time for tone management, increase passive range of motion, and splinting to appropriately position thumb for "functional bimanual assistance". A subsequent OT	F 318	Brace was put on resident but did not fit well. Referred to OT and they are working with her regarding proper splinting and positioning. All splint orders were checked at the month end to verify that they were placed correctly on the Treatment sheet and being done correctly. No other discrepancies found. In-service done with OT on 12/7/12 regarding how to correctly write orders-no as needed orders for residents unable to communicate the need for the splint and no trial orders written without follow-up. QA coordinator assign staff to perform weekly monitoring of all new orders to ensure that any written for splints are transcribed correctly and written documentation will be maintained. Any discrepancies will be corrected and documented. QA committee will review documentation monthly to evaluate effectiveness and modify plan if needed. This will continue until full compliance maintained. All splint orders will be reviewed every month by nursing administration staff during MAR/TAR review to ensure that all orders have been correctly transcribed so that nursing staff are documenting and administering orders properly. This will ensure correction is sustained.	

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progress note dated 01/28/12 indicated Resident #25 was discharged from OT services on 01/26/12 and needed an orthotic to assist in left hand positioning.

Review of a care plan dated 07/04/12, and continued for 90 days on 08/29/12, indicated Resident #25 required a restorative active range of motion program. The stated goal was for Resident #25 to maintain strength in her bilateral lower extremities. Interventions included to assist the resident with exercises as instructed by rehab and notify the nurse or rehab for any increased stiffness. An additional care plan dated 07/04/12 stated Resident #25 had impaired physical mobility and a self care deficit related to debility, left hip fracture, CVA with left hemiplegia, and severe arthritis. Neither of the care plans noted range of motion or the use of a splint for Resident #25's left hand.

Review of current Physician's orders for 11/01/12 through 11/30/12 revealed an order with an origination date of 01/17/12 for a left thumb splint to be worn as needed and may be removed for bathing or initial wearing tolerance trial.

An observation of Resident #25 on 11/14/12 at 9:16 AM revealed her left thumb was positioned in the palm of her hand with her fingers closed over her thumb. Her finger tips did not touch the palm of her hand. When asked if she was able to open the fingers on her left hand Resident #25 stated, "I work them". Resident #25 proceeded to take her right hand and fully extend her four fingers and move her thumb out of her palm. The interview further revealed Resident #25 could not recall the last time she wore the splint on her left

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F 318	Continued From page 6 hand. During a staff interview on 11/14/12 at 9:51 AM Nurse #1 stated Resident #25's left hand was contracted and she did not wear a splint. An interview with Nurse #2 on 11/15/12 at 3:35 PM revealed she had cared for Resident #25 for several months and did not recall a splint for her left hand. During an interview on 11/16/12 at 8:30 AM the Restorative Nursing Coordinator stated Resident #25 currently received stretching to bilateral knees and range of motion to bilateral lower extremities per therapy recommendations. The Restorative Nursing Coordinator did not recall orders for range of motion or the use of a splint for Resident #25's left hand. An interview with the Nursing Service Coordinator (NSC) on 11/16/12 at 9:17 AM revealed nurse aides (NAs) typically applied splints and the nurse was responsible for signing off on the treatment record when they verified it had been applied. The NSC reviewed Resident #25's electronic treatment record and stated the last time a nurse documented the splint had been applied to her left hand was on 05/01/12. The NA electronic documentation system was also reviewed and revealed the splint was not listed on Resident #25's profile to alert the NAs. The NSC could not explain how the treatment record entry for the splint had not been initialed since 05/01/12. Interview with NA #3 on 11/16/12 at 9:25 AM revealed she had cared for Resident #25 for about a year and did not recall a splint for her left	F 318		

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hand. NA #3 further stated she provided range of motion exercises to Resident #25 when she assisted her with activities of daily living.

During a follow up interview on 11/16/12 at 9:30 AM the NSC reported she had looked for and did not locate Resident #25's splint in her room but had found the box in the treatment room.

On 11/16/12 at 11:30 AM the Therapy Services Director observed Resident #25 's left hand and noted her left thumb was positioned in the palm of her hand with her fingers closed over her thumb. When asked by the Therapy Director Resident #25 was able to extend her four fingers to 75% of normal range of motion and her thumb to 50% of normal range of motion. When aided by her right hand she was able to obtain full extension of her fingers and nearly full extension of her left thumb. The Therapy Director stated Resident #25 still needed a splint to prevent a fixed contracture of her thumb.

An interview was conducted with the Director of Nursing (DON) on 11/16/12 at 1:45 PM. The DON stated when Resident #25's Physician's order for the splint was transcribed it was entered as an "as needed treatment" on the electronic treatment record. The DON further stated the order should have been clarified by the nurse and also entered into the NAs electronic documentation system. The DON explained if the splint had been entered as a routine order on the electronic treatment record it would have flagged until it was initialed by a nurse.