

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

PRINTED: 11/27/2012
FORM APPROVED
OMB NO. 0938-0391

DEC 19 2012

DEC 19 2012

12/12/12 - Scan
12/15/12 - Receipt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2012
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NAME OF PROVIDER OR SUPPLIER LENOIR MEMORIAL HOSPITAL TCU	STREET ADDRESS, CITY, STATE, ZIP CODE 100 AIRPORT RD KINSTON, NC 28501
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(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
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F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure that the placement of a feeding tube for 1 of 3 residents (#24) was checked prior to the administration of medications. The findings include:</p> <p>The facility policy titled Tube Feedings, gastric revised 10/06/12 included the following " to check tube patency and position, remove the cap or plug from the feeding tub and use a syringe to inject 5 to 10 ml (milliliters) of air through the tube to be sure the tube is in the stomach. "</p> <p>1. Resident #24 was admitted to the facility on 10/02/12 with cumulative diagnosis that included S/P (status post) CVA (stroke) Dysphagia and needing a feeding tube. The resident was assessed on the most recent MDS (minimum data set) dated 10/06/12 as being cognitively impaired and as being dependent on staff for all ADL 's (activities of daily living.) In addition, the resident was assessed as requiring a feeding tube. The resident 's CAA 's (care area</p>	F 322	<p>Corrective action was accomplished for those residents found to be affected by the deficient practice on the day of survey. Nurse #1 was immediately re-educated by the Director of Nursing in regard to the expectations of the facility's policy, Tube Feedings, gastric. This was followed by 1:1 re-education of the nursing staff working for the upcoming 24 hours by the Director of Nursing followed by several group educational sessions for the remainder of the staff.</p> <p>To address a corrective action for those residents having potential to be affected by the same deficient practice the facility's entire patient census was inspected to ensure there were no other patients with nasogastric or gastrostomy tubes for the purpose of tube feedings or medication administration. None were found.</p> <p>To ensure systematic changes are made and the deficient practice will not reoccur several steps were taken. During the initial step the Director of Nursing developed an enhanced policy to govern the safe utilization of nasogastric and gastrostomy tubes with a primary focus on placement verification and medication administration. All (100%) of the TCU nursing staff will be educated in regard to the newly revised policy as evidenced by their signature on an attendance sheet by December 19, 2012. The nursing staff will also receive a personal copy of the policy for their future reference. Further, all (100%) of the TCU nursing staff will have their understanding of the revised policy validated by performing the procedure on an actual or simulated patient while being directly observed on 3 separate occasions by the Director of Nursing or designee by December 19, 2012.</p> <p>The aforementioned plan will be fully implemented by December 19, 2012 after which time the facility will ensure the corrections are achieved and sustained through the organization's QA program. Corrective actions implemented will be evaluated for effectiveness by developing a QA tool that incorporates the essential elements / key steps from the policy. This quality assurance tool will be utilized to evaluate the performance of nursing staff during verification of placement and medication administration through nasogastric or gastrostomy tubes.</p>	December 19, 2012
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nancy S. Beck</i>	TITLE PRESIDENT & CEO	(X6) DATE 12.04.12
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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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M.P.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345296	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2012
NAME OF PROVIDER OR SUPPLIER LENOIR MEMORIAL HOSPITAL TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 100 AIRPORT RD KINSTON, NC 28501	
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F 322	Continued From page 1 assessments) indicated that the resident required a feeding tube and was at risk for dehydration and aspiration. The resident's care plan dated 10/02/12 indicated " resident will not experience any episodes of aspiration related to feedings during this stay." The interventions included " elevate HOB (head of bed) 30 - 45 degrees at all times and observe for aspiration and tendency to aspirate feedings " During a medication administration observation on 11/18/12 at 5:320 PM , Nurse #1 prepared the medication by placing the pill into a cup and crushing the pill and adding some water to the pill contents. Nurse #1 then went into the residents room disconnected the tube from the feeding pump and administered the medication. " During an Interview with the Director of Nursing on 11/19/12 3:15 PM it was revealed " I would expect the nurse to check the placement of the tube every time a medication is administered. " During an interview with Nurse #1 on 11/20/12 at 8:17 AM it was revealed " I typically do not check the placement for the GT (gastrostomy tube) but I would always check for the NG (nasogastric tube). It is much more likely that a resident would aspirate with a NG than with a GT. "	F 322	Continued from page 1 The Director of Nursing, or designee, will conduct 30 (n=30) random observations of nursing staff performing verification of placement and medication administration through nasogastric or gastrostomy tubes of patients or simulated patients each month for the next 4 months of until a 95% compliance level has been achieved (whichever is greater). To ensure the plan of correction for verification of placement and medication administration through nasogastric or gastrostomy tubes is integrated into the quality assurance system of the facility, monitoring will continue to be performed quarterly, after a 95% compliance level is achieved, to ensure compliance is sustained.	December 19, 2012
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;	F 328	Corrective action was taken immediately during survey, on November 20, 2012, for the one resident found to be affected by the deficient practice. Immediately upon becoming aware of the deficient practice, the Director of Nursing conducted a thorough assessment of Resident #24's toenails which confirmed the resident needed to be seen by a Podiatrist. A plan of care was developed, an appointment was made with a Podiatrist, transportation was arranged and the patient was seen by the Podiatrist on November 27, 2012, with a return appointment for December 3, 2012.	December 19, 2012

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F 328	<p>Continued From page 2</p> <p>Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide toenail care for 1 of 4 dependent residents (#24.) The findings include:</p> <p>1. Resident #24 was admitted to the facility on 10/02/12 with cumulative diagnosis that included S/P (status post) CVA (stroke) Dysphagia, requiring a feeding tube, Dementia and Diabetes Mellitus. The resident was assessed on the most recent MDS (minimum data set) dated 10/06/12 as being cognitively impaired and as being dependent on staff for all ADL 's(activities of daily living..) According to the medical record the resident was bed bound due to the use of a wound vac. A review of the medical record revealed that the resident had skin assessments weekly but there was no documentation related to toenails.</p> <p>The resident was observed on 11/20/12 at 10:00 AM during skin rounds. The resident 's toe nails were observed to be long, (about 1/4 inch over top of the toe), thick and some of the nails appeared to be twisting.</p> <p>During an interview with Nurse #1 on 11/20/12 at 10:15 AM it was revealed " it is difficult for us to</p>	F 328	<p>Continued from page 2</p> <p>To address corrective action for those residents having potential to be affected by the same deficient practice the facility's entire patient census was inspected by November 21, 2012 to ensure there were no other patients for which the facility failed to provide nail care. None were found.</p> <p>To ensure the deficient practice will not reoccur, systematic changes will be made to the initial nursing assessment processes by December 19, 2012. The Director of Nursing, in collaboration with the organization's IT department, will develop and execute a screen within the nursing initial assessment portion of the electronic medical record which will que and guide the nursing staff through a thorough assessment of the resident's toenails. A plan of care will be developed to provide toenail care which will be driven by the initial assessment.</p> <p>The aforementioned plan will be fully implemented by December 19, 2012 after which time the facility will ensure the corrections are achieved and sustained through the organization's QA program. Corrective actions implemented will be evaluated for effectiveness by developing a QA tool that will evaluate: 1) the completeness of the toenail assessment, 2) a plan of care was developed to provide toenail care, and 3) the toenail assessment is accurate and care was provided.</p> <p>The Director of Nursing, or designee, will monitor thirty (n=30) open medical records each month to ensure the toenail assessment was complete and a plan of care to provide toenail care was developed and executed, if needed. This monitor will be performed each month for the next 4 months or until a 95% compliance level has been achieved (whichever is greater). Additionally, direct resident observations will be made by the Director of Nursing or designee to validate the accuracy of the toenail assessment and to ensure toenail care was provided. Thlrty (n=30) random observations of resident's toenails will be performed each month and compared to the toenail assessment and care documented in the electronic medical record.</p> <p>To ensure the plan of correction for providing toenail care is integrated into the quality assurance system of the facility, monitoring will continue to be performed quarterly, after a 95% compliance level is achieved, to ensure compliance is sustained.</p>	December 19, 2012

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NAME OF PROVIDER OR SUPPLIER LENOIR MEMORIAL HOSPITAL TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 100 AIRPORT RD KINSTON, NC 28501	
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F 328	Continued From page 3 get a podiatrist to come here, we do have the equipment here to try and trim them. She is a diabetic and since the nails are so thick I would not expect a nurse aide to try and trim them. We can try to get a podiatrist to see her. " During an interview with the Director of Nursing (DON) on 11/20/12 at 10:38 AM it was revealed " I would expect staff to alert the charge nurse that the resident had an issue with the toe nails. This resident is on (name of an anticoagulant) so I would not expect staff to cut the nails but certainly to tell someone. Sometimes we can send a resident to the podiatrist if they are able to be transported but (name of resident) would be difficult to transport. We will need to have a podiatrist to see her. " A few minutes later the DON indicated that she had seen the residents toenails and that they were in need of cutting.	F 328		

PARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID

PRINTED: 12/14/2012
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345295	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2012
NAME OF PROVIDER OR SUPPLIER LENOIR MEMORIAL HOSPITAL TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 100 AIRPORT RD KINSTON, NC 28501	
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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 facility is Type I Fire Restive construction , and is equipped with an automatic sprinkler system.	K 000		Jan. 21, 2013
K025 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 12/11/2012 the following Life Safety item was observed as noncompliant with the smoke partition, specific findings include: There were unsealed penetrations in the rated smoke wall above cross corridor doors leading to the nurses station from restorative dining, and the elevator lobby leading into the corridor. NOTE: This deficiecle was verified corrected	K 025	During the Life Safety Survey on December 11, 2012 action was taken to correct the deficient practice cited. The unsealed penetration in the rated smoke wall above cross corridors leading to the Nurses Station from restorative dining, and the elevator lobby leading into the corridor were sealed by the organization's Plant Engineering Department. The deficiency was verified corrected before the end of the Life Safety Survey. To identify other issues having the potential to affect residents by the same deficient practice, the entire area occupied by the Transitional Care Unit was inspected for unsealed penetrations in smoke barrier walls above the ceiling tiles the day following survey. Only one (1) penetration was found during the inspection, which was repaired on that same day (December 12, 2012) by the organization's Plant Engineering Department.	Jan. 21, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary E. Hack* TITLE *PRESIDENT + CEO* (X6) DATE *12.27.12*

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K 025	Continued From page 1 before the end of the Life Safety Survey. CFR#: 42 CFR 483.70 (a)	K 025	Continued from page 1 To ensure the deficient practice does not recur an "Above Ceiling Access" policy was developed to alert Plant Engineering when workmen access the area above the ceiling tiles. As prescribed within the policy, "All fire and smoke barrier penetrations shall be repaired on the same day the penetrations are made." Further, the Engineering Department will inspect for proper sealing of any smoke and fire barrier penetrations following any workmen who are allowed access above the ceiling. The corrective action will be monitored semi-annually during Environmental Safety Team (EST) Rounds on the Transitional Care Unit. One member of the EST is dedicated to inspecting the space above ceiling tiles to ensure there are no unsealed penetrations in smoke barrier walls. To enhance this monitor, during the final quarter of the year the organization's Plant Engineering Department will inspect the space above the ceiling tiles on the Transitional Care Unit each month.	Jan. 21, 2013

[Handwritten signature]