

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345162</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE:  <b>6/20/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GASTONIA HEALTHCARE AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>416 N HIGHLAND ST GASTONIA, NC</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<p><b>F 156</b></p>	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 156</b>	<p>Continued From Page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility failed to provide notice of Medicare non-coverage (Resident #36) prior to the ending of Medicare services for 1 of 3 sampled residents reviewed for liability notices.</p> <p>The findings are:</p> <p>Review of a Medicare non-coverage letter for Resident #36 occurred on 06/19/13 at 5:15 PM. The letter documented that Medicare services would end for Resident #36 on 05/6/13. The letter was signed by Resident #36 on 05/9/13.</p> <p>An interview with the administrator on 06/19/13 at 5:43 PM revealed that notices of Medicare non-coverage were to be provided to residents prior to the ending of Medicare services to notify residents of their appeal rights. The administrator stated she had no explanation regarding Resident #36 receiving and signing her Medicare non-coverage letter after Medicare services ended.</p> <p>An interview on 06/20/13 at 09:00 AM with the human resources coordinator revealed she took over the responsibility of notifying residents of Medicare non-coverage on 5/1/13. She stated she knew that residents should be notified at least a few days prior to the ending of Medicare services, but could not remember or explain why the Medicare non-coverage letter for Resident #36 was not signed by the Resident until after Medicare services ended on 5/6/13.</p>		

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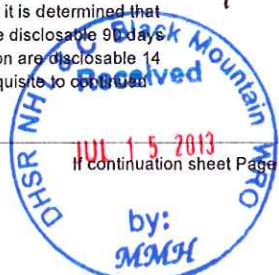
NAME OF PROVIDER OR SUPPLIER  GASTONIA HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 416 N HIGHLAND ST GASTONIA, NC 28052
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F 000  F 332 SS=D	<p>INITIAL COMMENTS</p> <p>There were no deficiencies cited as a result of the complaint investigation. Event ID C2QR11.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by three medication errors out of twenty-six opportunities, resulting in a medication error rate of 11.5%, for 3 of 5 residents observed during medication pass (Residents #47, #141 and #61).</p> <p>The findings included:</p> <p>1. On 06/18/13 at 4:36PM Nurse #1 was observed administering medications to Resident #47. Nurse #1 administered senokot S one tablet and ferrous sulfate 325 milligrams (mg). No other medications were administered.</p> <p>A review of Resident #47's medical record revealed a physician order for artificial tears 2 drops to both eyes.</p> <p>On 06/18/13 at 5:22PM Nurse #1 was interviewed. Nurse #1 acknowledged she had not administered the artificial tears per the physician order and stated it must have been an oversight.</p>	F 000  F 332	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The facility will ensure that it is free of Medication error rates of five percent Or greater.</p> <p>Resident #47 and #41 were Administered omitted medications Immediately by nurses 1 &amp; 2.</p> <p>Resident # 61 order for Senokot was clarified, rewritten and corrected on The Medication Administration Record by the nurse educator.</p> <p>The residents are receiving their Medications as ordered. The identified residents were observed by nurses #1, 2 and 3, with No negative outcomes noted from the delay in administration of meds or Senokot 2 tabs. MD was notified by the nurse educator upon clarification.</p> <p>Licensed nurses were in-serviced by the Nurse Educator, including the five rights medication administration and the necessity to have a working knowledge of</p>	6/18/2013  7/11/2013
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shanna Brown* TITLE: *Administrator* (X6) DATE: *7/12/13*

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F 332	<p>Continued From page 1</p> <p>An interview with the Director of Nursing (DON) on 06/20/13 at 1:16PM revealed she expected the nurses to carefully check the medication administration record (MAR) to ensure medications were not missed with medication pass.</p> <p>2. On 06/18/13 at 4:45PM, Nurse #2 was observed administering medications to Resident #141. She administered pravastatin 80 milligrams (mg), Renvela 1600mg and novolog insulin 10 units per sliding scale for a blood sugar of 486. No other medications were administered.</p> <p>A review of Resident #141's medical record revealed a physician's order for novolog insulin 2 units before meals.</p> <p>On 06/18/13 at 5:26PM Nurse #2 was interviewed. Nurse # 2 acknowledged she did not administer the scheduled dose of insulin and the physician would have expected the scheduled dose to be administered as ordered in conjunction with the sliding scale.</p> <p>An interview with the Director of Nursing (DON) on 06/20/13 at 1:16PM revealed she expected the nurses to carefully check the medication administration record (MAR) to ensure medications were not missed with medication pass.</p> <p>3. On 06/18/13 at 4:06PM, Nurse #3 was observed administering medications to Resident #61. The nurse administered ferrous sulfate 325 milligrams (mg), lamictal 25mg, colace 100mg, senokot 2 tablets, kepra 500mg, lipitor 40mg</p>	F 332	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>medications. Medication administration observations were immediately conducted on nurses #1, 2, 3 and return competency in place.</p> <p>Medications pass audits will be conducted by Director of Nursing, Nurse Managers, Nurse Educator and/or Pharmacy Consultant randomly. They will audit 2 nurses weekly for four weeks, then monthly for three months.</p> <p>Data results will be reviewed and analyzed at the facilities monthly quality assurance meeting (QA) for three months with a subsequent plan of correction as needed.</p>		

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F 332	Continued From page 2 and miralax 17 grams.  A review of Resident #61's medical record revealed an order dated 04/01/13 for senokot S 1 tablet twice daily.  Review of the June 2013 medication administration record (MAR) revealed the order was written senokot 2 1 tablet twice daily.  During an interview with Nurse #3 on 06/18/13 at 5:04PM, Nurse #3 acknowledged she administered 2 tablets of senokot not 1 tablet of senokot S. The nurse explained she was not familiar with what senokot 2 was and so administered 2 tablets of senokot. She further explained she should have read the order more closely.  An interview with the Director of Nursing (DON) on 06/20/13 at 1:16PM revealed she would have expected the nurse to have clarified the order against the chart prior to administering the medication. The DON also added she expected the nurses to carefully check the medication administration record (MAR) to ensure medications were not missed with medication pass.	F 332	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS  Each resident receives and the facility provides food prepared in a form designed to meet individual needs.  This REQUIREMENT is not met as evidenced by:	F 365	Resident #49 diet order was clarified by Licensed Nurse and written per physician order for puree consistency.	6/20/2013	

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F 365	<p>Continued From page 3</p> <p>Based on observations, staff interviews, and record review the facility failed to provide a diet in a form to meet resident need for 1of 3 residents sampled with mechanically altered diets. (Resident #49)</p> <p>The findings included:</p> <p>Resident #49 was admitted 09/14/12 with diagnoses of oral phase muscle weakness and dysphagia.</p> <p>A physician's order dated 09/24/12 indicated Resident #49 was to receive a mechanical soft diet with puree meats.</p> <p>A dysphagia discharge summary dated 11/19/12 assessed Resident #49 as requiring an oral pureed diet with thin liquids.</p> <p>A physician order dated 11/07/12 indicated a speech recommendation for change in diet consistency to pureed foods to increase safe oral intake and per resident request.</p> <p>Review of Resident #49's medical record revealed no mention of oral pain. A dental consult dated 01/07/13 indicated no chewing problems and no oral pain. The dental consult made no recommendations for dentures.</p> <p>A quarterly minimum data set (MDS) dated 05/02/13 assessed Resident #49 as cognitively intact and requiring a mechanically altered diet. The MDS did not code the resident as having mouth pain or discomfort.</p> <p>A plan of care dated 05/29/13 indicated Resident</p>	F 365	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>Resident #49 was seen by dentist.</p> <p>A diet audit was conducted by the Registered Dietician, DON, and Nurse Educator to ensure the residents are receiving the correct consistency modified diets as ordered by the physician.</p> <p>The Registered Dietician re-educated the dietary staff on ensuring the proper diet consistencies and therapeutic diets are served. The Nurse Educator re-educated the staff on checking tray card and meals for accuracy prior to serving.</p> <p>Dietary Manager will complete a tray accuracy audit at the end of the tray line daily x 1 week and then weekly x 3 months.</p>	<p>7/1/2013</p> <p>6/20/2013</p> <p>7/11/2013</p>
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F 365	<p>Continued From page 4</p> <p>#49 was at risk for nutritional decline related to requiring a mechanically altered diet with an intervention to provide meals as per physician order.</p> <p>During an interview with Resident #49 on 06/17/13 at 1:05 PM, Resident #49 stated, " I only have 3 or 4 teeth and they used to blend the food up for me so I could eat it but they don't do that anymore." Resident #49 also stated since she had been moved to her current room, she had not received her pureed diet. Resident #49 added she could not chew her meats or vegetables because it caused her mouth pain. She further explained she had to suck the juices out of the meats and vegetables then spit them out because they were too "stringy". Resident #49 explained she had told the nurse aides (NA) and the nurses that she could not eat the food at the current consistency because it made her gums sore.</p> <p>Observation of Resident #49 on 06/19/13 at 5:56 PM revealed Resident #49 was sitting in her wheelchair eating her dinner meal. Resident #49's meal consisted of mashed potatoes, stewed tomatoes and mechanically chopped stewed beef. At 5:59 PM Resident #49 was observed to place the tomatoes in her mouth, attempt to chew and then spit the tomato into a napkin. At 6:02 PM she was noted to place the beef in her mouth, attempt to chew and spit the beef into another napkin. The Resident stated at 6:02 PM the tomatoes have hard parts I cannot chew and the meat is too "stringy".</p> <p>Review of the meal tray card revealed the diet printed at the top of the card was mechanical soft</p>	F 365	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Data results will be reviewed and analyzed at the facilities monthly quality assurance meeting (QA) for three months with a subsequent plan of correction as needed.</p>		

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F 365	<p>Continued From page 5</p> <p>with puree meats and in the right hand corner of the card was a square box containing "MECH SOFT".</p> <p>During an interview with the dietary manager (DM) on 06/19/13 at 6:08 PM, the DM revealed Resident #49 had received mechanical soft beef at her dinner meal. The DM added a new system for printing the tray cards was initiated approximately 4-6 weeks ago but she was unable to determine how long Resident #49 had been receiving the wrong consistency. The DM added she was unaware Resident #49 meal consistency caused her mouth pain.</p> <p>Interview with Director of Nursing (DON) on 06/20/13 at 10:02 AM revealed dietary orders were transcribed by the nurses. The nurse would also fill out a dietary communication sheet which was sent to dietary with the new diet information. The data processor then entered the new order into the data base so the monthly physician order sheets would be printed with the correct diet. The DON added she did not know why the puree diet was not being followed as a dietary communication sheet was completed.</p> <p>Interview with the data entry person on 06/20/13 at 1:00 PM revealed she was trained to only enter in diet orders written by the registered dietitian (RD) and not to enter any orders written by therapy.</p> <p>Interview with NA #1 on 06/20/13 at 1:58 PM revealed Resident #49 would complain that she could not eat some things and could not chew up her food because she had only a few teeth.</p>	F 365			



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F 365	<p>Continued From page 6</p> <p>Interview with NA #2 on 06/20/13 at 2:07 PM revealed Resident #49 would inform the NA at every meal that she would have to "gum" the food because she could not chew the food due to only having four teeth. The NA added Resident #49 told everybody often enough that everyone knew. The NA also stated she had not told the nurse because everyone was aware.</p> <p>Interview with Nurse #4 on 06/20/13 at 2:06PM revealed she was unaware of Resident #49 having difficulty with her meals or any pain with chewing. The Nurse explained Resident #49 mentioned she only had a few teeth and a dental consult was arranged in January, however Resident #49 never mentioned difficulty with chewing or eating and it was not reported to her by the NAs.</p> <p>During an interview with Director of Nursing (DON) on 06/20/13 at 3:03PM, the DON stated she would have expected the NAs to have communicated Resident #49's complaints of pain or difficulty chewing with her teeth to the nurse so that it would have been addressed.</p> <p>During an interview with the Administrator on 06/20/13 at 3:11 PM, revealed she was unaware that Resident #49 was having oral pain when chewing her meals.</p> <p>During a follow up interview with the DON on 06/20/13 at 3:37 PM, the DON stated the physician was made aware of Resident #49's concerns and ordered a swish and swallow to address the discomfort to her gums and the facility would ensure she received the correct diet.</p>	F 365			
F 367	483.35(e) THERAPEUTIC DIET PRESCRIBED	F 367			

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F 367 SS=D	<p>Continued From page 7 BY PHYSICIAN</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to serve a physician ordered puree diet for 1 of 3 sampled residents with a mechanically altered diet ordered. (Resident #49)</p> <p>The findings included:</p> <p>Resident #49 was admitted 09/14/12 with diagnoses of oral phase muscle weakness and dysphagia.</p> <p>A physician order dated 11/07/12 indicated a speech recommendation for change in diet consistency to pureed foods to increase safe oral intake and per resident request.</p> <p>A nutrition/ nursing communication for Resident #49 dated 11/07/12 indicated to change the diet consistency to puree.</p> <p>A dsypsghia discharge summary dated 11/19/12 assessed Resident #49 as requiring an oral pureed diet with thin liquids.</p> <p>A quarterly minimum data set (MDS) dated 05/02/13 assessed Resident #49 as cognitively intact and requiring a mechanically altered diet.</p> <p>A plan of care dated 05/29/13 indicated Resident</p>	F 367	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>Resident #49 diet order was clarified by Licensed Nurse and written per physician order.</p> <p>The Registered Dietician conducted an audit to determine the prescribed diets are correct on remaining residents.</p> <p>Licensed Nurses in-serviced by nurse educator, assuring implementation of dietary order being placed on the Medication Administration Record at the change of a dietary status, written on the 24 hour report, dietary slip placed in the dietary communication box, and information communicated in morning meeting with dietary manager.</p>	<p>6/20/2013</p> <p>6/20/2013</p> <p>7/11/2013</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/20/2013
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F 367	<p>Continued From page 8</p> <p>#49 was at risk for nutritional decline related to requiring a mechanically altered diet with an intervention to provide meals as per physician order.</p> <p>A review of the June 2013 physician order sheet indicated a diet order, with original start date of 09/14/12 for a Mechanical soft diet with puree meats and regular liquids.</p> <p>During an interview with Resident #49 on 06/17/13 at 1:05 PM, Resident #49 stated, " I only have 3 or 4 teeth and they used to blend the food up for me so I could eat it but they don't do that anymore." Resident #49 added she could not chew her meats or vegetables because it caused her mouth pain. She further explained she had to suck the juices out of the meats and vegetables then spit them out because they were too "stringy". Resident #49 also stated she had told the nurse aides (NA) and the nurses that she could not eat the food at the current consistency.</p> <p>Observation of Resident #49 on 06/19/13 at 5:56 PM revealed Resident #49 was sitting in her wheelchair eating her dinner meal. Resident #49's meal consisted of mashed potatoes, stewed tomatoes and mechanically chopped stewed beef. At 5:59 PM Resident #49 was observed to place the tomatoes in her mouth, attempt to chew and then spit the tomato into a napkin. At 6:02 PM she was noted to place the beef in her mouth, attempt to chew and spit the beef into another napkin.</p> <p>Interview with Resident #49 on 06/19/13 at 6:05PM revealed she could not chew the beef it was too "stringy " and the tomatoes had hard</p>	F 367	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>The DON/designee will audit Medication Administration Record, 24 hour report and dietary tray card for five resident's weekly for four weeks then monthly for three months.</p> <p>Data results will be reviewed and analyzed at the facilities monthly quality assurance meeting (QA) for three months with a subsequent plan of correction as needed.</p>		

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F 367	<p>Continued From page 9</p> <p>areas that she was unable to chew. Review of the meal tray card revealed the diet printed at the top of the card was mechanical soft with puree meats and in the right hand corner of the card was a square box containing "MECH SOFT " .</p> <p>Interview on 06/20/13 at 9:20 AM with the Speech therapist revealed the speech therapist wrote diet recommendation orders which were usually followed unless the registered dietitian (RD) consulted with Speech regarding the need to change the recommendations to accommodate resident preferences.</p> <p>Interview with the RD on 06/20/13 at 9:31 AM revealed the speech therapist was able to write orders for diet changes and those orders were to be followed as written.</p> <p>Interview with the dietary manager (DM) on 06/20/13 at 9:35 AM revealed she did not know why the diet was incorrect and did not have the 11/07/12 dietary communication sheet as the old DM did not keep them.</p> <p>Interview with Director of Nursing (DON) on 06/20/13 at 10:02 AM revealed dietary orders were transcribed by the nurses. The nurse would also fill out a dietary communication sheet which was sent to dietary with the new diet information. The data processor then entered the new order into the data base so the monthly physician order sheets would be printed with the correct diet. The DON added she did not know why the puree diet was not being followed as a dietary communication sheet was completed.</p>	F 367			

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F 367	Continued From page 10  Interview with the data entry person on 06/20/13 at 1:00 PM revealed she was trained to only enter in diet orders written by the RD and not to enter any orders written by therapy.  During an interview with the Administrator on 06/20/13 at 1:44 PM, the Administrator explained she did not understand how the diet order was overlooked. The Administrator also stated she believed the reason Resident #49 had gotten the wrong diet was because the dietary communication sheet was misplaced or overlooked.	F 367			