| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345085 | A. BUILDING _____ B. WING _____ | 02/20/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDWIN MORGAN CTR OF SCOTLAND M | 617 PEDEN ST LAURINBURG, NC 28352 |

| (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 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | F 272 | [redacted]<br><br>F 272 Comprehensive Assessments<br><br>1. To address the resident that has been affected by this alleged deficient practice, resident #44 was assessed by therapy and picked up by OT for 5X/wk. He was also assessed for the presence/absence of contractures, for the need for adaptive equipment (and the appropriate adaptive equipment has been provided). He was also evaluated for ROM and splinting needs (and appropriate services have been provided). All changes to his needs have been noted in his care plan. | 3/20/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

C. J. [illegible], EXECUTIVE DIRECTOR — 3/13/14

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

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| F 272 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility failed to assess a resident at risk for contractures for 1 of 1 resident's reviewed with impaired range of motion (ROM). The facility also failed to assess the need for adaptive dining equipment for 1 (Resident #44) of 30 residents reviewed for activities of daily living (ADLs).<br><br>Findings included:<br><br>1. Resident # 44 was admitted on 3/30/12 with cumulative diagnoses of cerebral vascular accident (CVA) dysphagia, aphasia and right side hemiplegia. The quarterly Minimum Data Set (MDS) dated 12/3/13 indicated resident #44 had severe cognitive impairment and required extensive assistance for his activities of daily living except for eating. Resident #44 was not receiving any occupational therapy (OT) services or restorative services for his right upper extremity at the time of this assessment. The quarterly MDS did not reflect any therapy or restorative services and a review of the care plan dated 11/15/13 did not address the decline in ROM to the right hand.<br><br>A review of resident #44's admission MDS dated 4/9/12 and his annual MDS care area assessment (CAA) dated 3/27/13 indicated the risk of contractures existed and care planning with interventions were indicated.<br><br>A review of the medical record revealed a physician order dated 7/10/13 for occupational therapy to evaluate resident #44's right hand | F 272 | 2. To address other residents with the potential to be affected by this alleged deficient practice, the EMC Therapy Department will screen/evaluate every resident for the presence/absence of contractures, the need for adaptive equipment and the need for range of motion services.<br><br>3. To ensure that this alleged deficient practice does not reoccur, all new orders will be noted on the 24-hour nursing report by the charge nurse. All new orders have been and will continue to be reviewed during morning clinical meeting M-F by administrative team with appropriate notification identified as completed. All new orders on the weekend | |

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| F 272 | Continued From page 2<br>contracture.<br><br>A review of the care plan conference dated 9/24/13 with the activities director, MDS nurse and the social worker present indicated the restorative program was discontinued passive ROM during routine care and application of the splint to the right lower leg. The care plan was updated to reflect the changes. A review of the care plan conference dated 12/17/13 indicated the director of nursing (DON), the MDS nurse, the rehabilitation manager and the social worker were in attendance. It was noted that there was no decline and his current care plan would continue. There was no noted change in resident #44's right hand ROM.<br><br>In an observation on 2/17/14 at 12:30 PM, resident #44 was eating lunch using his left hand. The right hand was observed in his lap with his fingers curled inward touching the palm of the hand. In another lunch observation on 2/18/14 at 12:10 PM, resident #44's right hand was observed in his lap with his fingers curled inward touching the palm of the hand. On both occasions, there was no observed splint.<br><br>In an interview on 2/18/14 at 3:37 PM, the rehabilitation manager stated the evaluation for the order for OT on 7/10/13 was not done. She stated " It got missed. "<br><br>In an observation on 2/18/14 at 3:40 PM, resident #44 was in the bed with his right hand noted on his lap. The right hand was noted flexed at the wrist with the fifth and forth finger more contracted than the other fingers. All of the fingers were flexed at the knuckles with the hand appearing about 60% closed. There was no splint | F 272 | have been and will continue to be reviewed by the nursing supervisor with appropriate notification identified as completed. All Licensed Staff will be inserviced by the DON with regards to noting new orders on the 24-hour report and communicating any new therapy orders to the therapy program manager or appropriate designee. All nursing staff will be inserviced to use the "Hey Therapy" notice card to let the Therapy Department know of any resident change in condition. The MDS Coordinator will follow through with completion of any comprehensive assessments as needed. | |

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| F 272 | Continued From page 3<br>in place.<br><br>In an interview on 2/19/14 at 10:00 AM, the MDS nurse stated the CAA completed 3/27/13 was coded for contracture risk. The MDS stated she did proceed to care plan for activities of daily living assistance but did not address the contracture risk. The MDS nurse stated she relied on her own observation, chart review, staff charting and interviews to determine an accurate assessment. The MDS nurse stated for the 12/3/13 quarterly assessment, she noted resident #44 ' s right hand bent but it could be opened. The MDS stated it was not bent when he came on admission. For the 9/17/13 quarterly assessment, she did not see the order dated 7/10/13 because she would not have gone back that far. The MDS nurse stated when completing a MDS, she looks back at the documentation for 14 days.<br><br>In a In an interview on 2/19/14 at 1:15 PM, the nurse consultant and administrator stated expectation would be for MDS to do more than a 14 day look back when assessing all residents. It would also be the expectation that the MDS nurse to assess each resident visually, review documentation and interview staff to determine accurate an assessment.<br><br>2. Resident # 44 was admitted on 3/30/12 with cumulative diagnoses of cerebral vascular accident (CVA) dysphagia, aphasia and right side hemiplegia. The quarterly Minimum Data Set (MDS) dated 12/3/13 indicated resident #44 had severe cognitive impairment and required extensive assistance for his activities of daily living except for eating for which he was coded as independent. | F 272 | 4. The Executive Director, or appropriate designee, will monitor as follows to assure that this alleged deficient practice does not recur:<br>a. Compliance with plan will be monitored 5 times weekly during morning Administrative meeting X 4 weeks by administrative personnel for appropriate actions taken.<br>b. This will be followed by weekly monitoring during morning Administrative meeting X 8 weeks by administrative personnel for appropriate actions taken.<br>c. This will be followed by monthly X3 months, then quarterly X2 quarters and as needed. | |

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| F 272 | Continued From page 4<br><br>A review of the care plan dated 11/15/13 indicated the resident #44 required no more than supervision to eat. A care plan for resident #44's percutanous endoscopic gastrostomy (PEG) tube was used for medication administration along with water boluses three times daily and he was on a cardiac mechanically altered diet. The head of his bed was to be at 45 degrees during and for 30 minutes after meals. Staff was to monitor for difficulties with the current diet, monitor for signs or symptoms of aspiration, trouble chewing or swallowing and report them to the physician.<br><br>A review of the care plan conference dated 12/17/13 indicated the director of nursing (DON), the MDS nurse, the rehabilitation manager and the social worker were in attendance. It was noted that there was no decline and his current care plan would continue.<br><br>In an observation on 2/17/14 at 12:30 PM, resident #44 was attempting to eat pureed barbeque ribs with a spoon with his left hand. The meat was observed sliding off to right side of plate. There was no plate guard in use. It was noted that the rehabilitation manager was sitting at the same table assisting another resident.<br><br>In an observation on 2/18/14 at 12:10 PM, resident #44 had a plate guard on his plate that extended 1/3 of the surface edge of the plate at the 12: 00 o'clock position. The plate was observed still sitting inside the plate warmer. Resident #44 was observed using a spoon with his left hand. When resident #44 attempted to get a spoon full on green beans, the plate was observed spinning around and the plate guard was observed at the 9:00 o'clock position. At | F 272 | d. The QM committee will discuss the compliance with the audits in the facility's monthly QA meeting X 6 months, then quarterly X 2 quarters and document such discussion in the facility QM meeting minutes.<br>e. Revisions will be made and documented in the meeting minutes as needed by QM committee members.<br>f. Appropriate employees will be re-inserviced to applicable revisions. Revisions in the plan will require monitoring to begin again at 4a, 4b and 4c.<br><br>With the exception of the monitoring program outlined above, all other actions will be completed on or before March 20, 2014. | |

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| F 272 | Continued From page 5<br>12:13 PM, the administrator was observed turning the plate still resting in the plate warmer so that the plate guard was in the 3:00 o'clock position. At 12:15 PM, resident #44 again attempted to get a spoon full of green beans when the plate turned to the 12:00 o'clock position. The green beans were observed falling into resident #44 ' s lap. He was able to eat about 75% of the green beans. At 12:20 PM, resident #44 attempted to use the spoon to pick up a bite of ziti. He was unable to get the ziti onto his spoon. The plate guard was observed in the 12:00 o'clock position. Resident #44 laid the spoon down and picked up the cookie and ate it. Nursing assistant #4 was at another table in the dining room feeding another resident.<br><br>In an interview on 2/19/14 10:00 AM, the MDS nurse stated she coded resident #44's quarterly MD assessment as independent with eating. The MDS nurse stated there had been no functional change with eating that she was aware of and she coded the MDS the way the aides documented during the look back period. She stated resident #44 did not require any staff assistance with meals and staff only periodically checked on him. She stated staff one on one staff observation would be coded as supervision. The MDS nurse stated his weight was stable and he consistently consumed 50-75% of his meals. The MDS nurse stated she relied on her own observation, chart review, staff charting and interviews to determine an accurate assessment. The MDS nurse stated she coded resident #44 as supervision for eating for the quarterly assessment dated 9/17/13. She was unable to explain why supervision was needed on the September assessment and independent on the 12/3/13 quarterly assessment. The MDS nurse | F 272 | | |

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| F 272 | Continued From page 6<br>stated she updated the care plan when changes occurred and she added the plate guard to resident #44's care plan yesterday.<br><br>In an interview on 2/19/14 1:15 PM, the nurse consultant and the administrator stated expectation was for the MDS nurse assessed a problem with eating during the 12/3/13 quarterly assessment and resident #44 and receive supervision for all meals. | F 272 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and | F 279 | [redacted] F 279 Care Plans<br><br>1. To address the resident that has been affected by this alleged deficient practice, resident #44 was assessed by therapy and picked up by OT for 5X/wk. He was also assessed for the need for adaptive equipment and the appropriate adaptive equipment has been provided. He was also evaluated for ROM and splinting needs and appropriate services have been provided. All changes to his needs have been noted in his care plan. | 3/20/14 |

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| F 279 | Continued From page 7<br>record review, the facility failed to he facility failed to develop interventions for a resident identified at risk for contractures for 1 of 1 resident reviewed for impaired range of motion (ROM). The facility also failed to provide interventions for a resident who needed adaptive dining equipment for 1 (Resident #44) of 30 residents reviewed for activities of daily living (ADLs).<br><br>Findings included:<br><br>1. Resident # 44 was admitted on 3/30/12 with cumulative diagnoses of cerebral vascular accident (CVA) dysphagia, aphasia and right side hemiplegia. The quarterly Minimum Data Set (MDS) dated 12/3/13 indicated resident #44 had severe cognitive impairment and required extensive assistance for his activities of daily living except for eating. Resident #44 was not receiving any occupational therapy (OT) services or restorative services for his right upper extremity at the time of this assessment. The quarterly MDS did not reflect any therapy or restorative services and a review of the care plan dated 11/15/13 did not address the decline in ROM to the right hand.<br><br>A review of resident #44's admission MDS dated 4/9/12 and his annual MDS care area assessment (CAA) dated 3/27/13 indicated the risk of contractures existed and care planning with interventions were indicated.<br><br>A review of the medical record revealed a physician order dated 7/10/13 for occupational therapy to evaluate resident #44's right hand contracture.<br><br>A review of the care plan conference dated | F 279 | 2. To address other residents with the potential to be affected by this alleged deficient practice, once the EMC Therapy Department has screened/evaluated every resident for the presence/absence of contractures, the need for adaptive equipment and the need for range of motion services, the care plans will be<br><br>adjusted for every resident having a new need in any of these areas.<br><br>3. To ensure that this alleged deficient practice does not reoccur, all new orders will be noted on the 24-hour nursing report by the charge nurse. All new orders have been and will continue to be reviewed during morning clinical meeting M-F by | |

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| F 279 | Continued From page 8<br>9/24/13 with the activities director, MDS nurse and the social worker present indicated the restorative program was discontinued passive ROM during routine care and application of the splint to the right lower leg. The care plan was updated to reflect the changes. A review of the care plan conference dated 12/17/13 indicated the director of nursing (DON), the MDS nurse, the rehabilitation manager and the social worker were in attendance. It was noted that there was no decline and his current care plan would continue. There was no noted change in resident #44's right hand ROM.<br><br>In an observation on 2/17/14 at 12:30 PM, resident #44 was eating lunch using his left hand. The right hand was observed in his lap with his fingers curled inward touching the palm of the hand. In another lunch observation on 2/18/14 at 12:10 PM, resident #44's right hand was observed in his lap with his fingers curled inward touching the palm of the hand. On both occasions, there was no observed splint.<br><br>In an interview on 2/18/14 at 3:37 PM, the rehabilitation manager stated the evaluation for the order for OT on 7/10/13 was not done. She stated " it got missed."<br><br>In an interview on 2/19/14 at 10:00 AM, the MDS nurse stated the CAA completed 3/27/13 was coded for contracture risk. The MDS stated she did proceed to care plan for activities of daily living assistance but did not address the contracture risk. The MDS nurse stated she relied on her own observation, chart review, staff charting and interviews to determine an accurate assessment. The MDS nurse stated for the 12/3/13 quarterly assessment, she noted resident | F 279 | administrative team with appropriate notification identified as completed. All new orders on the weekend have been and will continue to be reviewed by the nursing supervisor with appropriate notification identified as completed. All Licensed Staff will be inserviced by the DON with regards to noting new orders on the 24-hour report and communicating any new therapy orders to the therapy program manager or appropriate designee. All nursing staff will be inserviced to use the "Hey Therapy" notice card to let the Therapy Department know of any resident change in condition. The MDS Coordinator will follow through with updating of care plans of any resident receiving a new order and any change to their plan of care.<br><br>4. The Executive Director, or appropriate designee, will monitor as follows to assure | |

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| F 279 | Continued From page 9<br>#44's right hand bent but it could be opened. The MDS stated it was not bent when he came on admission.. For the 9/17/13 quarterly assessment, she did not see the order dated 7/10/13 because she would not have gone back that far. The MDS nurse stated when completing a MDS, she looks back at the documentation for 14 days.<br><br>In a In an interview on 2/19/14 at 1:15 PM, the nurse consultant and administrator stated expectation would be for the MDS nurse assess each resident visually, review documentation and interview staff to determine accurate a care plan with appropriate interventions.<br><br>2. Resident # 44 was admitted on 3/30/12 with cumulative diagnoses of cerebral vascular accident (CVA) dysphagia, aphasia and right side hemiplegia. The quarterly Minimum Data Set (MDS) dated 12/3/13 indicated resident #44 had severe cognitive impairment and required extensive assistance for his activities of daily living except for eating for which he was coded as independent.<br><br>A review of the care plan dated 11/15/13 indicated the resident #44 required no more than supervision to eat. A care plan for resident #44's percutanous endoscopic gastrostomy (PEG) tube was used for medication administration along with water boluses three times daily and he was on a cardiac mechanically altered diet. The head of his bed was to be at 45 degrees during and for 30 minutes after meals. Staff was to monitor for difficulties with the current diet, monitor for signs or symptoms of aspiration, trouble chewing or swallowing and report them to the physician. | F 279 | that this alleged deficient practice does not recur:<br><br>a. Compliance with plan will be monitored 5 times weekly during morning Administrative meeting X 4 weeks by administrative personnel for appropriate actions taken.<br>b. This will be followed by weekly monitoring during morning Administrative meeting X 8 weeks by administrative personnel for appropriate actions taken.<br>c. This will be followed by monthly X3 months, then quarterly X2 quarters and as needed. | |

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| F 279 | Continued From page 10<br>A review of the care plan conference dated 12/17/13 indicated the director of nursing (DON), the MDS nurse, the rehabilitation manager and the social worker were in attendance. It was noted that there was no decline and his current care plan would continue.<br><br>In an observation on 2/17/14 at 12:30 PM, resident #44 was attempting to eat pureed barbeque ribs with a spoon with his left hand. The meat was observed sliding off to right side of plate. There was no plate guard in use. It was noted that the rehabilitation manager was sitting at the same table assisting another resident.<br><br>In an observation on 2/18/14 at 12:10 PM, resident #44 had a plate guard on his plate that extended 1/3 of the surface edge of the plate at the 12: 00 o'clock position. The plate was observed still sitting inside the plate warmer. Resident #44 was observed using a spoon with his left hand. When resident #44 attempted to get a spoon full on green beans, the plate was observed spinning around and the plate guard was observed at the 9:00 o'clock position. At 12:13 PM, the administrator was observed turning the plate still resting in the plate warmer so that the plate guard was in the 3:00 o'clock position. At 12:15 PM, resident #44 again attempted to get a spoon full of green beans when the plate turned to the 12:00 o'clock position. The green beans were observed falling into resident #44's lap. He was able to eat about 75% of the green beans. At 12:20 PM, resident #44 attempted to use the spoon to pick up a bite of ziti. He was unable to get the ziti onto his spoon. The plate guard was observed in the 12:00 o'clock position. Resident #44 laid the spoon down and picked up the cookie and ate it. Nursing assistant #4 was at | F 279 | d. The QM committee will discuss the compliance with the audits in the facility's monthly QA meeting X 6 months, then quarterly X 2 quarters and document such discussion in the facility QM meeting minutes.<br>e. Revisions will be made and documented in the meeting minutes as needed by QM committee members.<br>f. Appropriate employees will be re-inserviced to applicable revisions. Revisions in the plan will require monitoring to begin again at 4a, 4b and 4c.<br><br>With the exception of the monitoring program outlined above, all other actions will be completed on or before March 20, 2014. | |

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| | 345085 | A. BUILDING _____ B. WING _____ | 02/20/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EDWIN MORGAN CTR OF SCOTLAND M | 517 PEDEN ST LAURINBURG, NC 28352 |

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| F 279 | Continued From page 11<br>another table in the dining room feeding another resident.<br><br>In an interview on 2/18/14 at1:00 PM, NA #4 who was assigned the dining room on 2/17/14 and again on 2/18/14 stated normally she was made aware when a change was made or a new device was ordered for a resident but she was not made aware that resident #44 had a plate guard or how it should be set up to enable him to eat effectively.<br><br>In an interview on 2/18/14 at 2:09 PM, the restorative aide stated she did not have any resident on restorative dining. She stated she only had resident #44 briefly in September for splinting of his right leg. She stated she was employed by the therapy department and had been at the facility for approximately one year.<br><br>In an interview on 2/19/14 10:00 AM, the MDS nurse stated she coded resident #44's quarterly MD assessment as independent with eating. The MDS nurse stated there had been no functional change with eating that she was aware of and she coded the MDS the way the aides documented during the look back period. She stated resident #44 did not require any staff assistance with meals and staff only periodically checked on him. The MDS nurse stated she updated the care plan when changes occurred and added plate guard to resident #44's care plan yesterday. The MDS nurse stated monitoring for diet tolerance as stated in care plan dated 11/15/13, did not mean he required supervision. The MDS nurse stated she updated the care plan when changes occurred and she added the plate guard to resident #44's care plan yesterday. | F 279 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 279 | Continued From page 12<br>In an interview on 2/19/14 1:15 PM, the nurse consultant and the administrator stated expectation was for the MDS nurse to have care planned and receive supervision for all meals with the 12/17/13 quarterly assessment. | F 279 | | |
| F 311 SS=D | 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review the facility failed to provide adaptive dining equipment to maintain independent feeding for 1 of 30 residents (Resident #44) sampled for activities of daily living (ADLs).<br><br>Findings Included:<br><br>Resident # 44 was admitted on 3/30/12 with cumulative diagnoses of cerebral vascular accident (CVA) dysphagia, aphasia and right side hemiplegia. The quarterly Minimum Data Set (MDS) dated 12/3/13 indicated resident #44 had severe cognitive impairment and required extensive assistance for his activities of daily living except for eating. Resident #44 was coded as independent for eating.<br><br>A review of the care plan dated 11/15/13 indicated the resident #44 required no more than supervision to eat. A care plan for resident #44's percutanous endoscopic gastrostomy (PEG) tube was used for medication administration and water | F 311 | [redacted]<br><br>F 311 Treatment/Services<br><br>1. To address the resident that has been affected by this alleged deficient practice, resident #44 was assessed by therapy and picked up by OT for 5X/wk. He was also assessed for the need for adaptive equipment and the appropriate adaptive equipment has been provided. He was also evaluated for ROM and splinting needs and appropriate services have been provided. All changes to his needs have been noted in his care plan.<br><br>2. To address other residents with the potential to be affected by this alleged deficient practice, once the EMC Therapy Department has screened/evaluated every | 3/20/14 |

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| F 311 | Continued From page 13<br>boluses only and he was on a cardiac mechanically altered diet. The head of his bed (HOB) was to be at 45 degrees during the meal and for 30 minutes after meals. Staff was to monitor for difficulties with the current diet, monitor for signs or symptoms of aspiration, trouble chewing or swallowing and report them to the physician. A review of resident #44 ' s weights over the last year indicated the resident had not had a significant weight loss.<br><br>In an observation on 2/17/14 at 12:30 PM, resident #44 was attempting to eat pureed barbeque ribs with a spoon using his left hand. The meat was observed sliding off to the right side of plate. There was no plate guard in use. It was noted that the rehabilitation manager was sitting at the same table assisting another resident.<br><br>In an observation on 2/18/14 at 12:10 PM, resident #44 had a plate guard on his plate that extended 1/3 of the surface edge of the plate at the 12: 00 o'clock position. The plate was observed still sitting inside the plate warmer. Resident #44 was observed using a spoon with his left hand. When resident #44 attempted to get a spoon full on green beans, the plate was observed spinning around and the plate guard was observed at the 9:00 o'clock position. At 12:13 PM, the administrator was observed turning the plate still resting in the plate warmer so that the plate guard was in the 3:00 o'clock position. At 12:15 PM, resident #44 again attempted to get a spoon full of green beans when the plate turned to the 12:00 o'clock position. The green beans were observed falling into resident #44's lap. He was able to eat about 75% of the green beans. At 12:20 PM, resident #44 attempted to use the | F 311 | resident for the presence/absence of contractures, the need for adaptive equipment and the need for range of motion services, treatments/services will begin for every resident having a new need in any of these areas.<br><br>3. To ensure that this alleged deficient practice does not reoccur, all new orders will be noted on the 24-hour nursing report by the charge nurse. All new orders have been and will continue to be reviewed during morning clinical meeting M-F by administrative team with appropriate notification identified as completed. All new orders on the weekend have been and will continue to be reviewed by the nursing supervisor with appropriate notification identified as completed. All Licensed Staff | |

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| F 311 | Continued From page 14<br>spoon to pick up a bite of ziti. He was unable to get the ziti onto his spoon. The plate guard was observed in the 12:00 o'clock position. Resident #44 laid the spoon down and picked up the cookie and ate it. Nursing assistant #4 was at another table in the dining room feeding another resident.<br><br>In an interview on 2/18/14 at 12:28 PM, the dietary manager stated she received a nursing order yesterday for a plate guard. The dietary manager stated she worked at a neighboring facility and her facility was contracted in October 2013 to provide meals for the residents at this facility. She stated she was unaware of any eating problems regarding resident #44. She stated she relied on a review of the weights and the staff to report needed interventions.<br><br>In an interview on 2/18/14 at1:00 PM, NA #4 who was assigned the dining room on 2/17/14 and again on 2/18/14 stated normally she was made aware when a change was made or a new device was ordered for a resident but she was not made aware that resident #44 had a plate guard or how it should be set up to enable him to eat effectively.<br><br>In an interview on 2/18/14 at 2:15 PM, NA #1stated resident #44 ate all of his breakfast and that there was a plate guard on his plate this morning. She was unable to state how the plate should be set up to maximize the benefit of the plate guard.<br><br>In an interview on 2/18/14 at 4:35 PM, the occupational therapist (OT) stated she was not aware of any change in resident #44' s eating status. She stated she was contacted today about | F 311 | will be inserviced by the DON with regards to noting new orders on the 24-hour report and communicating any new therapy orders to the therapy program manager or appropriate designee. All nursing staff will be inserviced to use the "Hey Therapy" notice card to let the Therapy Department know of any resident change in condition. The Therapy Manager will initiate any new treatment/service as<br><br>determined appropriate by the evaluation and assessment.<br><br>4. The Executive Director, or appropriate designee, will monitor as follows to assure that this alleged deficient practice does not recur:<br><br>g. Compliance with plan will be monitored 5 times weekly during morning Administrative meeting X 4 weeks by administrative personnel for appropriate actions taken.<br>h. This will be followed by weekly monitoring during morning Administrative meeting X 8 weeks by administrative personnel for appropriate actions taken. | |

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| F 311 | Continued From page 15<br>evaluating resident #44 for a plate guard and eating difficulties. The OT stated when the hospital was providing meals, it was on different plates that were divided but since the new facility started providing the meals, the food was served on a plate with no raised edges.<br><br>In an interview on 2/19/14 at 8:30 AM, NA# 3 stated he was assigned to work with resident #44 everyday. NA #3 stated resident #44 normally eats 75% of his breakfast and lunch and only required set up and supervision for eating. NA #3 stated there was a plate guard on resident #44 breakfast plate this morning. He stated he was not given any directions on how the plate should be placed to prevent food spillage. NA #3 confirmed that plates provided by the hospital were divided and resident #44 was likely spilling more of his meals with the new flat plates.<br><br>In an interview on 2/19/14 at 9:30 AM, the administrator stated the dietary services contracted with the hospital ended on 10/15/13. He stated he was unaware of any problems with the flat plates for resident #44.<br><br>In an interview on 2/19/14 1:15 PM, the administrator and the nurse consultant were interviewed on 2/19/14 1:15 PM. They indicated resident #44's need for a plate guard should have been identified earlier. | F 311 | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>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 | |

i. This will be followed by monthly X3 months, then quarterly X2 quarters and as needed.

j. The QM committee will discuss the compliance with the audits in the facility's monthly QA meeting X 6 months, then quarterly X 2 quarters and document such discussion in the facility QM meeting minutes.

k. Revisions will be made and documented in the meeting minutes as needed by QM committee members.

l. Appropriate employees will be re-inserviced to applicable revisions. Revisions in the plan will require monitoring to begin again at 4a, 4b and 4c.

With the exception of the monitoring program outlined above, all other actions will be completed on or before March 20, 2014. 3/20/14

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| F 318 | Continued From page 16<br>range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility failed to prevent a decline in range of motion (ROM) of the right hand for 1 (resident #44) of 1 residents reviewed for impaired ROM.<br><br>Findings included<br><br>Resident # 44 was admitted to the facility on 3/30/12 with cumulative diagnoses of cerebral vascular accident (CVA) dysphagia, aphasia and right side hemiplegia. The quarterly Minimum Data Set (MDS) dated 12/3/13 indicated resident #44 had severe cognitive impairment, required extensive assistance for his activities of daily living except for eating. The quarterly MDS did not reflect any therapy or restorative services. A review of the care plan dated 11/16/13 did not address the decline in ROM to right hand.<br><br>A review of the OT hospital discharge summary dated 3/30/12 indicated that resident #44 required right upper extremity stretching and positioning to prevent a contracture. The admission nursing assessment to the facility dated 3/30/12 indicated resident #44 presented with no contracture to his right hand. A review of the facility OT discharge summary dated 5/24/12 indicated therapy ended at this time. The reason indicated by OT was that resident #44 became inconsistent with participation and it was recommended that services could be resumed if resident #44 felt | F 318 | F 318 Range of Motion<br><br>1. To address the resident that has been affected by this alleged deficient practice, resident #44 was assessed by therapy and picked up by OT for 5X/wk. He was also assessed for the need for adaptive equipment and the appropriate adaptive equipment has been provided. He was also evaluated for ROM and splinting needs and appropriate services have been provided. All changes to his needs have been noted in his care plan. | |

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| F 318 | Continued From page 17<br>motivated to continue with therapy. There was no mention of a right hand contracture and no referral to restorative for ROM services. There was no record of any additional OT services in the medical record until a physician order was given on 7/10/13 for OT to evaluate the right hand.<br><br>In an observation on 2/17/14 at 12:30 PM, resident #44 was eating lunch using his left hand. The right hand was observed in his lap with his fingers curled inward touching the palm of the hand. In another lunch observation on 2/18/14 at 12:10 PM, resident #44's right hand was observed in his lap with his fingers curled inward touching the palm of the hand. On both occasions, there was no observed splint.<br><br>In an interview on 2/18/14 at 3:37 PM, the rehabilitation manager stated the order for the OT evaluation on 7/10/13 was not done. She stated " it got missed. "<br><br>In an observation on 2/18/14 at 3:40 PM, resident #44 was in the bed with his right hand noted on his lap. The right hand was noted flexed at the wrist with the fifth and forth finger more contracted than the other fingers. All of the fingers were flexed at the knuckles with the hand appearing about 60% closed. There was no splint in place.<br><br>In an interview on 2/18/14 at 4:35 PM, the OT stated she was not notified of an order for an OT evaluation for resident #44. The OT recalled resident #44 from his admission and stated the right side including his hand was flaccid at that time. The OT stated he had no contractures and that his right arm was often rested on a pillow and | F 318 | 2. To address other residents with the potential to be affected by this alleged deficient practice, once the EMC Therapy Department screens/evaluates every resident for the need for range of motion services, ROM services will begin for every resident having a new need in this area.<br><br>3. To ensure that this alleged deficient practice does not reoccur, all new orders will be noted on the 24-hour nursing report by the charge nurse. All new orders have been and will continue to be reviewed during morning clinical meeting M-F by administrative team with appropriate notification identified as completed. All new orders on the weekend have been and will continue to be reviewed by the nursing | |

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| F 318 | Continued From page 18<br>his bed side table.<br><br>On 2/18/14 at 6:33 PM, an observation of the OT evaluating the right hand was done. The OT described resident #44 as having increased flexor tone in his right hand and that a contracture was fixed. The OT stated the increased flexor tone could lead to a contracture if untreated. The OT was able to open resident #44 ' s hand but it had to be done slowly. Next the OT attempted to abduct (move the arm away from the body) the shoulder when resident #44 expressed pain.<br><br>In an interview on 2/19/14 at 8:30 AM, NA #3 stated he was assigned resident #44 everyday and he was always able to open resident #44 ' s hand enough to ensure it was clean and that there no breakdown. NA #3 stated resident #44 had never had a splint for his right hand. NA #3 recalled therapy made aware of his right hand contracture but could not recall how long ago therapy was made aware or who made them aware.<br><br>In an interview on 2/19/14 at 1:15 PM, the nurse consultant and administrator stated expectation would be no resident to have a functional decline while residing at the facility<br><br>In an interview on 2/19/14 at 3:00 PM, the physician stated someone saw a need in July 2013 and it was overlooked. The physician stated he could not recall if resident #44 was admitted with a right hand contracture. | F 318 | supervisor with appropriate notification identified as completed. All Licensed Staff will be inserviced by the DON with regards to noting new orders on the 24-hour report and communicating any new therapy orders to the therapy program manager or appropriate designee. All nursing staff will be inserviced to use the "Hey Therapy" notice card to let the Therapy Department know of any resident change in condition. The Therapy Manager will initiate any new ROM as determined by the evaluation and assessment. | |