

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

PRINTED: 03/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2014
NAME OF PROVIDER OR SUPPLIER JESSE HELMS NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1411 DOVE STREET MONROE, NC 28111		
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F 000	INITIAL COMMENTS	F 000	Disclaimer: 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 this 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.		
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 observation, interviews with a resident and staff and review of the medical record, the facility failed to provide timely extensive staff assistance with eating for 1 of 3 sampled residents dependent on staff for activities of daily living. (Resident #49) The findings included: Resident #49 was admitted to the facility 12/31/12. Diagnoses included Alzheimer's dementia, anorexia, and dysphagia. Review of physician's orders revealed Resident #49 received a pureed diet and high calorie supplements. Additionally, a physician's order dated 11/19/13 required Resident #49 to receive one to one staff assistance with meals due to pocketing solid food. Review of an annual minimum data set dated 01/18/14 revealed Resident #49 was assessed	F 312	F312 CNA #3 and CNA #4 were re-educated by the Nursing Supervisor on 2/19/2014. Resident #49 meal tray is delivered and appropriate assistance is immediately provided. The Medical Records of facility residents were reviewed by the MDS Coordinator on 3/11/2014 to identify those residents requiring extensive assistance with eating. Residents requiring extensive assistance with eating will be observed by the Director of Nursing and Administrative Nursing Staff to ensure that appropriate assistance provided. Nursing staff will be educated by the Director of Nursing/ and/ or Staff Educator on proper sequence of meal delivery and the requirement to provide appropriate assistance to residents requiring extensive assistance with eating. The Director of Nursing and/or Administrative Nursing Staff will monitor five residents identified as requiring extensive staff assistance with eating weekly for 12 weeks to ensure that the proper meal delivery sequence and appropriate		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] **Black/Mary A. Henderson**

TITLE

Administrator

(X6) DATE

March 13, 2014

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 312	<p>Continued From page 1 with impaired cognition and required extensive staff assistance with eating due to holding food/residuals in her mouth/cheeks.</p> <p>Review of a care plan, revised 01/22/14, revealed Resident #49 required extensive staff assistance with activities of daily living (ADL) to include assistance with eating. Interventions included respond promptly to requests for assistance, provide necessary assistance at meal time, and encourage as needed to promote optimal meal intake.</p> <p>Resident #49 was observed on 02/19/14 at 9:01 AM in her room after receipt of her breakfast meal from nurse aide (NA) #3. NA #3 placed the meal on the Resident's over bed table, uncovered the breakfast meal, the Resident expressed her preferences regarding condiments and NA #3 set up her meal. NA #4 entered the room to assist with positioning the Resident. NA #4 was observed to inform NA #3 that Resident #49 required one to one assistance with her meal; NA #4 left the room. NA #3 sat down to assist Resident #49 with breakfast. Prior to providing assistance, at 9:07 AM, NA #3 was called out of Resident #49's room to help distribute breakfast trays on another hall. Resident #49 was left with her breakfast meal in front of her and uncovered. Resident #49 sat with her hands in her lap and stared at her food until she dozed off to sleep at 9:19 AM. Resident #49 awoke at 9:21 AM, removed the straw from her juice, placed the straw in her mouth and with the straw in her mouth, made several unsuccessful attempts to insert the straw back in the apple juice. At 9:31 AM, NA #4 returned to the Resident's room and offered Resident #49 some juice. Resident #49 drank approximately 3 ounces of juice</p>	F 312	<p>assistance is provided. Staff found to have deficient practice will be re-educated as needed.</p> <p>Audit results will be shared with the Administrator weekly and with the facility Quality Assurance Process Improvement (QAPI) Committee monthly for 90 days. Further monitoring will be determined by the QAPI committee.</p>	3/20/14
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F 312	<p>Continued From page 2</p> <p>continuously at which time NA #4 said "You were thirsty weren't you?" Resident #49 shook her head up and down. NA #4 gave Resident #49 two bites of pureed eggs, which were observed as stiff and without any signs of steam, to which the Resident responded "I'm not too crazy about it." Resident #49 was asked by the surveyor if the food was warm enough to which the Resident replied "Huh, uh, I'm not eating it." NA #4 continued to feed Resident #49 pureed eggs without offering to reheat the food, Resident #49 held the pureed eggs in her mouth and responded "It doesn't taste good." Resident #49 removed the pureed eggs from her mouth with a napkin. As NA #4 fed Resident #49 pureed sausage, also stiff and without signs of steam, Resident #49 grimaced and shook her head back and forth, NA #4 stated to the resident "You don't like it?", to which Resident #49 responded "Uh, uh" while moving her head side to side. At 9:40 AM, NA #4 exited Resident #49's room to answer the call light for another resident; Resident #49's food was left uncovered. At 9:42 AM NA #4 returned to Resident #49's room and asked the Resident if she wanted anymore of her breakfast, the Resident moved her head side to side and responded "Uh, uh " Resident #49's breakfast tray was removed and placed on a cart.</p> <p>An interview was conducted on 02/19/14 at 09:43 AM with NA #4 who revealed she worked with Resident #49 once to twice weekly. NA #4 stated Resident #49 did not eat much, but drank fluids well and usually ate 25% of her meals. NA #4 stated that if she had to step away while feeding a resident when she returned she usually asked the resident if they want their food reheated, but she did not ask Resident #49, nor did she assess the temperature of the Resident's food because the</p>	F 312		

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F 312	<p>Continued From page 3</p> <p>Resident typically ate her meals very slowly and for this reason NA #4 stated that she thought Resident #49 did not like hot food.</p> <p>On 02/19/14 at 1:22 PM, Resident #49 was observed in her room assisted by NA #5 with her lunch meal. Resident #49 received prompt assistance with her lunch meal and ate 25% of her meal and drank 340 ml of her fluids. NA #5 stated that Resident #49 usually ate about 25% of her meals and could express meal preferences, including whether or not her food was hot.</p> <p>An interview with nurse #2 (charge nurse) occurred on 02/20/14 at 11:31 AM. The interview revealed that staff was trained to assist residents with meals who ate in their rooms by distributing meal trays first to residents who fed themselves, followed by those residents who required cueing and then lastly by those required to be fed. Nurse #2 stated meal trays should be left covered and on the cart to prevent staff from starting to feed someone and then getting up to go pass out a meal tray. Nurse #2 stated that if a staff member had to walk away from feeding a resident, the meal tray should be covered with the lid and then when the staff member returned, they should check to see if the food needed to be warmed and reheat it. Nurse #2 stated not offering to reheat a resident's food was not an acceptable practice.</p> <p>An interview on 02/20/14 at 3:15 PM with the director of nursing revealed she would expect that if a resident was fed by staff in their room, staff would not be pulled away from assisting with the meal, but if so, the meal should be covered and when staff returned, the staff should offer to</p>	F 312		

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F 312 F 332 SS=D	<p>Continued From page 4 reheat the meal for the resident.</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 observed medication passes, staff interviews and record review, the facility failed to administer a correct dose of medication (Resident #2) and omitted a medication (Resident #15) which did not ensure a medication error rate of less than 5%. There were 2 errors of 30 opportunities for error which resulted in a medication error rate of 6.6%. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 11/09/07.</p> <p>Review of a monthly physician order sheet for February 2013 revealed an order for the topical non-steroidal anti-inflammatory medication diclofenac sodium 1% gel, to apply 2 grams (g), as measured with a provided dosing card, topically by gently rubbing into bilateral shoulders twice daily at 9:00 AM and 9:00 PM.</p> <p>On 02/19/14 at 8:40 AM, Nurse #4 was observed at the Resident's bedside with a plastic dosing card used for diclofenac sodium gel 1%. The plastic dosing card was marked in the middle as 2g and at the end as 4g. Nurse #4 applied the gel from one end of the plastic dosing card the other end marked 4g, removed the medication</p>	F 312 F 332	<p>F332</p> <p>1. Nurse #4 was re-educated by the Accreditation Coordinator on 2/19/2014. Resident #2 was monitored and no negative outcome was observed.</p> <p>The medical records of facility residents will be reviewed by the Director of Nursing and Administrative Nursing Staff, to ensure that resident medications were provided as ordered.</p> <p>Licensed Nursing Staff will be educated on Medication Administration with particular emphasis on ensuring accurate dosage by the Consultant Pharmacist or the Staff Educator. The Consultant Pharmacist will observe Medication Administration Passes with two nurses each month. Additionally, the Director of Nursing/Nursing Supervisor will observe the medication administration pass with two nurses each month for three months. Nurses found to have deficient practice will be re-educated as needed.</p> <p>Results of this monitoring will be shared with the Administrator and Director of Nursing after each observed medication pass and with the facility Quality Assurance Process Improvement (QAPI) Committee monthly for 90 days. Further monitoring will be determined by the QAPI committee.</p>	

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F 332	<p>Continued From page 5</p> <p>from the card with gloved hands and rubbed it into Resident #2's left shoulder. Nurse #4 applied more medication on the plastic dosing card from one end of the plastic dosing card to the other end marked 4g, removed the medication from the card with gloved hands and rubbed it into Resident #2's right shoulder. While she was rubbing the medication into Resident #2's right shoulder, she stated she squeezed a ribbon of medication from one end of the measuring tool to the other end. Nurse #4 removed her gloves, washed her hands, discarded the plastic dosing card and left the Resident's room with the tube of medication.</p> <p>On 02/09/14 at 8:45 AM, Nurse #4 reviewed Resident #2's medication administration record (MAR) at the medication cart in the hallway and stated the order read to administer a 2g dose of medication for each shoulder. Nurse #4 obtained a plastic dosing card from the drawer in the medication cart where the medication was stored and stated she squeezed the medication from end to end which was a 4g dose. Nurse #4 stated she should have dispensed a 2g dose of medication for each shoulder.</p> <p>02/19/14 at 4:42 PM the Director of Nursing (DON was interviewed. She stated she expected nurses to cross check dispensed medication dosages with the MAR, making sure medications were administered by the right route and for the right patient, and then to recheck this again after the medication was administered. She stated for ointment medications that nurses were to use the measuring device provided with the medication by the manufacturer.</p> <p>2. Resident #15 was readmitted to the facility on</p>	F 332	<p>2. Nurse #1 was re-educated by the Accreditation Coordinator on 2/19/2014. Resident #15 did receive the medication and no negative outcome was observed.</p> <p>The Medical Records of facility residents will be reviewed by the Director of Nursing and Administrative Nursing Staff to ensure that resident medications were provided as ordered.</p> <p>Licensed Nursing Staff will be educated by the Consultant Pharmacist or the Staff Educator on Medication Administration with particular emphasis on ensuring residents receive all prescribed medications during each medication administration pass. The Consultant Pharmacist will observe Medication Administration Passes with two nurses each month. Additionally, the Director of Nursing or Nursing Supervisor will observe the Medication Administration Pass with two nurses each month for three months. Nurses found to have deficient practice will be re-educated as needed.</p> <p>Results of this monitoring will be shared with the Administrator and Director of Nursing after each observed medication pass and with the facility Quality Assurance Process Improvement Committee monthly for 90 days. Further monitoring will be determined by the QAPI committee.</p>	3/20/14	

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F 332	<p>Continued From page 6</p> <p>12/01/13 with diagnoses which included hypertension.</p> <p>Review of physician's orders dated 02/05/14 revealed direction to administer Carvedilol (used to treat hypertension) 12.5 milligrams twice daily and to hold for an apical pulse under 55 or when the systolic blood pressure was less than 95 mmHg (millimeters of mercury).</p> <p>Review of Resident #15's February 2014 Medication Administration Record (MAR) revealed the Carvedilol scheduled to be administered at 9:00 AM and 9:00 PM.</p> <p>Observation on 02/19/14 at 8:42 AM revealed Nurse #1 checked Resident #15's blood pressure and apical pulse. Nurse #1 announced a blood pressure measurement of 160/80 mmHg and the apical pulse of 72.</p> <p>Further observation on 02/19/14 at 8:44 AM revealed Nurse #1 prepared five medications to administer to Resident #15. The medications did not include Carvedilol. Nurse #1 administered the medications via Resident #15's feeding tube at 8:45 AM and flushed the tube with 240 milliliters of water. Nurse #1 exited the room.</p> <p>Interview with Nurse #1 on 02/19/14 at 9:51 AM revealed Resident #15 received all of the medications scheduled for administration at 9:00 AM. Nurse #1 explained she thought she administered the Carvedilol since she obtained Resident #15's blood pressure and apical pulse measurements.</p> <p>After review of Resident #15's MAR at 9:53 AM on 02/19/14, Nurse #1 explained the MAR sheet</p>	F 332		

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F 332	Continued From page 7 which contained direction to administer the Carvedilol was not in the section she used for the medication administration. Nurse #1 reported the MAR binder became undone earlier in the shift. Nurse #1 reported the MAR sheet with direction to administer the Carvedilol was not available for use and she did not administer the Carvedilol. Interview with the Director of Nursing on 02/19/14 at 1:40 PM revealed she expected staff to administer medications as ordered by the physician.	F 332			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 I. CNA #1 was re-educated regarding the proper use of the disinfecting wipes from the orange top container by the Infection Preventionist on 2/18/2014. Resident #2 has been monitored and no negative outcomes have been observed. Staff performing finger stick blood sugars will be observed and/ or interviewed by the Infection Preventionist and Administrative Nursing Staff regarding disinfecting glucometers with wipes from the orange top containers according to manufacturer's instructions. Nursing Staff will be educated by the Infection Preventionist or Staff Educator regarding disinfecting glucometers with wipes from the appropriate container according to manufacturer's instructions. The Infection Preventionist or Administrative Nursing Staff will monitor		

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F 441	<p>Continued From page 8</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to disinfect a glucose meter (used for blood sugar monitoring) after a finger stick blood sugar for 2 of 3 sampled residents observed for finger stick blood sugar checks (Residents #2 and #29).</p> <p>The findings included:</p> <p>1. Resident #2 was readmitted to the facility on 11/09/07 with diagnoses which included diabetes mellitus.</p> <p>Review of monthly physician's orders dated 02/05/14 revealed direction to obtain finger stick blood sugars (fsbs) before meals and at bedtime.</p> <p>Review of an orange topped disinfectant wipes container's label revealed the manufacturer's direction for disinfection required the surface to be thoroughly wet. The direction specified: "Treated surface must remain visibly wet for a full 4 minutes. Use additional wipes if needed to</p>	F 441	<p>five staff members performing finger stick blood sugars weekly for 12 weeks to observe the glucometer is disinfected with approved wipes according to manufacturer's instructions. Any staff member found with deficient practice will be re-educated as needed.</p> <p>Results of this monitoring will be shared with the Administrator and Director of Nursing weekly and with the facility Quality Assurance Process Improvement Committee monthly for 90 days. Further monitoring will be determined by the QAPI committee.</p> <p>2. CNA #2 and Nurse #2 were re-educated regarding disinfecting with wipes from the orange top container according to manufacturer's instructions by the Infection Preventionist on 2/18/2014 and on 2/19/2014. Resident #29 has been monitored and no negative outcomes have been observed.</p> <p>Staff performing finger stick blood sugars will be observed and/ or interviewed by the Infection Preventionist and Administrative Nursing Staff regarding disinfecting glucometers with wipes from the orange top container according to manufacturer's instructions.</p> <p>Nursing Staff will be educated by the Infection Preventionist or Staff Educator regarding disinfecting glucometers with</p>	

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F 441	<p>Continued From page 9</p> <p>assure continuous visible wetness for 4 minutes wet contact time." The container was located in a cupboard on the nursing unit.</p> <p>Observation of Nurse Aide (NA) #1 on 02/18/14 at 4:15 PM revealed she obtained Resident #2's fsbs by placing a strip with Resident #2's blood in the glucose meter. After removing the strip, NA #1 used a wipe from a container with an orange top. NA #2 wiped the glucose meter once and placed it in a charger.</p> <p>Interview with NA #1 on 02/18/14 at 4:20 PM revealed her usual practice was to wipe the surface and immediately place the glucose meter into the charger. NA #1 explained she wiped the shared glucose meter with the wipe each time she obtained a fsbs and there was no "set time" for saturation. NA #1 reported she did not realize the surface required visible wetness for 4 minutes.</p> <p>A second interview with NA #1 on 02/18/14 at 4:55 PM revealed she received training in disinfecting but forgot the time required for wetness.</p> <p>Interview with Nurse #2 on 02/19/14 at 4:09 PM revealed staff should wipe the glucose meter and wait 4 minutes until charge placement. Nurse #2 was not aware of the requirement for visible saturation for 4 minutes. Nurse #2 reported the directions given the staff did not include 4 minutes of visible saturation. Nurse #2 reported residents' blood sugars were checked by shared glucose meters.</p> <p>Interview with Nurse #3 on 02/19/14 at 4:14 PM revealed she oversaw the facility's infection</p>	F 441	<p>wipes from the appropriate container according to manufacturer's instructions. The Infection Preventionist or Administrative Nursing Staff will monitor five staff members each week performing finger stick blood sugars to observe the glucometer is disinfected with approved wipes according to manufacturer's instructions. Any staff member found with deficient practice will be re-educated as needed.</p> <p>Results of this monitoring will be shared with the Administrator and Director of Nursing weekly and with the facility Quality Assurance Process Improvement Committee monthly for 90 days. Further monitoring will be determined by the QAPI committee.</p>	3/20/14

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: 345097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2014
NAME OF PROVIDER OR SUPPLIER JESSE HELMS NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1411 DOVE STREET MONROE, NC 28111		
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F 441	<p>Continued From page 10</p> <p>control program. Nurse #3 explained the facility changed the type of wipes used for disinfection last week due to an outbreak of a gastrointestinal virus. Nurse #3 reported she directed staff to wipe the surface and keep the surface visibly wet for 4 minutes.</p> <p>2. Resident #29 was admitted to the facility on 12/21/12 with diagnoses which included diabetes mellitus.</p> <p>Review of monthly physician's orders dated 02/05/14 revealed direction to obtain finger stick blood sugars (fsbs) before meals and at bedtime.</p> <p>Review of an orange topped disinfectant wipes container's label revealed the manufacturer's direction for disinfection required the surface to be thoroughly wet. The direction specified: "Treated surface must remain visibly wet for a full 4 minutes. Use additional wipes if needed to assure continuous visible wetness for 4 minutes wet contact time." The container was located in a cupboard on the nursing unit.</p> <p>Observation on 02/19/14 at 3:50 PM revealed Nurse Aide (NA) #2 revealed she obtained Resident #29's fsbs by placing a strip with Resident #29's blood in the glucose meter. After removing the strip, NA #2 used a wipe from a container with an orange top. NA #2 wiped the glucose meter and placed it on the counter. The surface was visibly wet from 3:55 PM to 3:57 PM.</p> <p>Interview with NA #2 on 02/19/14 at 3:59 PM revealed she received direction to wet the surface with a wipe and wait 4 minutes until it could be placed in the charger. NA #2 explained she did not realize the surface was to remain visible wet</p>	F 441		

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F 441	<p>Continued From page 11</p> <p>so did not check the surface. NA #2 reported she received direction to wipe down the glucose meter and wait 4 minutes until charge placement.</p> <p>Interview with Nurse #2 on 02/19/14 at 4:09 PM revealed staff should wipe the glucose meter and wait 4 minutes until charge placement. Nurse #2 was not aware of the requirement for visible saturation for 4 minutes. Nurse #2 reported the directions given the staff did not include 4 minutes of visible saturation. Nurse #2 reported residents' blood sugars were checked by shared glucose meters.</p> <p>Interview with Nurse #3 on 02/19/14 at 4:14 PM revealed she oversaw the facility's infection control program. Nurse #3 explained the facility changed the type of wipes used for disinfection last week due to an outbreak of a gastrointestinal virus. Nurse #3 reported she directed staff to wipe the surface and keep the surface visibly wet for 4 minutes.</p>	F 441			