STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345314	A. BUILDING _____ B. WING _____	C 10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY HEALTH AND REHABILITATION CENTER	830 BETHANY CHURCH ROAD FOREST CITY, NC 28043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and cover bed pans, wash basins and bedside commode bowls stored on shelves in resident bathrooms in 2 bathrooms on 1 of 3 halls. The findings included: An observation was made on 10/13/15 at 3:30 PM and 10/14/15 at 2:15 PM of an unlabeled, uncovered bedside commode bowl and an unlabeled, uncovered bedpan on the shelf above the commode in the connecting bathroom between rooms 140 and 142. An observation was made 10/13/15 at 3:45 PM and 10/14/15 at 2:20 PM of an unlabeled, uncovered wash basin, 1 unlabeled, uncovered bedpan and 1 unlabeled, uncovered bedside commode bowl on the shelf above the commode in the connecting bathroom between rooms 137 and 139. An interview was conducted on 10/14/15 at 10:58 AM with nurse aide #4. She stated bed pans, wash basins and toilet seat bowls should be labeled and covered when stored in a resident bathroom. During an interview conducted on 10/14/15 at 3:47 PM the Director of Nursing stated all resident care items such as bed pans, wash basins and bedside commode bowls should be labeled with the resident name and room number and covered with a plastic bag before being	F 253	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. On 10/16/2015, the unlabeled and uncovered wash basins, bedside commode bowls and bedpans were removed from the connecting bathrooms of rooms 140-142 and 137- 139. New/clean wash basins, bedside commode bowls and bedpans were put back in place with covers that are labeled with resident name and room number for the rooms affected by the deficient practice. 2. All resident rooms has the potential to be affected by the same alleged deficient practice. An audit was conducted by the Housekeeping Director and DON of all resident rooms and bathrooms, no other residents were found to be affected by this deficient practice. Audit included personal	11/12/15

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

Electronically Signed | 11/04/2015

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F 253	Continued From page 1 stored in resident bathrooms.	F 253	care equipment storage - specifically bedpans, wash basins and bedside commode bowls. 3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing and Housekeeping Director conducted an in-service/ re-education for all Staff beginning on October 10/26/15 Regarding Storage and labeling of personal care equipment with resident name and room number and cleanliness of rooms and bathrooms. The facility's Ambassadors (team members who with residents routinely to identify concerns/ needs) will observe and inspect 10 residents room weekly for 4 weeks and then 10 every other week for 2 months to include observation of bedpans, wash basins and bedside commode bowls stored with resident name and room number. 4.The Administrator, Maintenance Director, Director of Nursing, and Housekeeping Director will review data obtained during facility audits and rounds; analyze the data and report patterns/ trends to the QAPI committee every other month for 6 months.The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 323	Continued From page 2	F 323		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to provide 1 of 2 sampled residents with securely fitting side rails. (Resident #113). The findings included: Resident #113 was admitted to the facility on 03/13/15 with diagnoses including a burn to his left arm, pain, weakness, and toxic encephalopathy. His admission Minimum Data Set (MDS) dated 03/20/15 coded him as being cognitively intact, requiring extensive assistance with activities of daily living including bed mobility and transfers and being nonambulatory. The Care Area Assessment dated 03/26/15 for activities of daily living skills (ADLs) stated he required assistance with his ADLs, was in the facility for rehabilitation and was expected to improve. The most recent MDS, a quarterly dated	F 323	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. The bed for resident #113 was removed from service and the resident room on 10/14/15. A newer model bed with a different side rail style was put into place for resident #113. 2. All resident beds have the potential to be affected by the same alleged deficient practice. An audit of all bed rails was conducted by the Maintenance Director on 10/16/15 of beds currently in use in the facility. Resident's whose side rails were assessed by Maintenance Director to be affected by alleged deficient practice,	11/12/15

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F 323	Continued From page 3 07/23/15, coded him with moderately impaired cognition (scoring a 12 out of 15 on the Brief Interview for Mental Status), requiring extensive assistance with ADLs including bed mobility and transfers, and being nonambulatory. A side rail assessment was completed on 09/16/15 which stated Resident #113 was unsteady and unable to stand by himself. The assessment noted side rails were indicated as they served as an enabler to promote independence. Observations made on 10/13/15 at 9:47 AM revealed the left side of Resident #113's bed was up against the wall and the right side of the bed was open towards the doorway and had a half length metal side rail in the upright position. It was very loose and wiggled back and forth (into and from the mattress) with some movement side to side (head to foot direction). At this time, Resident #113 stated the side rail had been loose that way for a while. The side rail was observed upright and loose when observed on 10/13/15 at 3:05 PM and on 10/14/15 at 8:33 AM. On 10/14/15 at 10:42 PM, Nurse Aide (NA) #1 stated during interview that Resident #113 was able and did use the side rail to turn himself when in bed. On 10/14/15 at 2:08 PM NA #2 was observed assisting Resident #113 transfer from his wheelchair to bed. With the gait belt applied and assistance from NA #2, Resident #113 stood and he shuffled around and into a sitting position. As Resident #113 began to scoot on the bed, he	F 323	were assessed by DON for actual need of side rail. Side rails were completely removed from beds of those residents who DON determined did not require side rails to assist with bed mobility. The residents, who DON assessed to need side rails for bed mobility, were provided a new style of side rail that was recommended by the manufacturer of the bed or bed was replaced with a bed whose side rails were not affected by the alleged deficient practice. All care plans have been updated by DON and or Unit Managers to reflect the need or removal of side rail based on the resident's side rail assessment. 3. Maintenance Director and designee will conduct rounds twice weekly for 4 weeks, to audit 10 beds. Audits will then be conducted bi-weekly for 2 months, to identify, document and correct any findings of loose side rails of any style, make or model. 4. Results of the rounds and audits will be tracked and analyzed, then reported to the QAPI committee by the Nursing Home Administrator, bi monthly for 6 months. The QAPI will take action as necessary to ensure continued compliance.	

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F 323	Continued From page 4	F 323		

attempted to reach the side rail for support. NA #2 guided his hand to the side rail which moved from the head of the bed to the foot of the bed.

An interview with NA #3 on 10/14/15 at 3:41 PM revealed Resident #113 will occasionally use the side rail for positioning. Together the side rail was observed to move both inward and sideways several inches. She stated she normally did not see the side rail that loose.

The Maintenance Director was interviewed on 10/14/15 at 3:47 PM. He stated that all side rails were checked monthly to ensure they fit close to the mattress and were tight. He stated the half metal side rails were "after market", meaning added to the bed when the full rails which came with the beds were removed. He stated some side rails just can't be any tighter, they don't get totally tight and there was movement. He further stated he checked and tightened rails in the facility approximately 2 weeks ago. At this time the Maintenance Director and surveyor observed Resident #113's side rail which was loose. He tightened the knob and noted there was still play in the side rail which loosened with immediate use. He explained there was only one bolt that secured the side rail to the bed which loosened easily. He stated there was no real fix for the looseness. He then stated the facility planned to order 56 new beds which would have had the quarter side rails which came with the beds to replace some of the old crank type beds which had the metal after market side rails, however, that plan had been canceled.

Interview with the Administrator on 10/15/15 at 9:57 AM revealed the metal half rails were an "after market" adaptation. She stated they did not

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F 323	Continued From page 5 stay tight after tightening and monthly rounds were made to tighten them and ensure they fit he bed to avoid being an accident hazard. Upon observation of Resident #113's side rail, the Administrator stated she did not think the looseness was a hazard. Observation on 10/15/15 at 10:12 PM revealed the side rail moved approximately 3 inches in each side to side direction of the bed and at least one inch in each head to toe direction. The Administrator provided undated instructions from the supply company relating to how to inspect side rails. The instructions included to "Inspect connectors on rails and tighten as necessary." In addition she provided evidence that the Maintenance Director checked the side rails monthly which was last completed on 10/08/15.	F 323		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and	F 412	Preparation, submission and	11/12/15

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F 412	Continued From page 6 resident interviews, the facility failed to make sure 1 of 3 residents sampled for dental needs was seen by the dentist. (Resident #113). The findings included: Resident #113 was admitted to the facility on 03/13/15 with diagnoses including a burn to his left arm, pain, weakness, and toxic encephalopathy. His admission Minimum Data Set (MDS) dated 03/20/15 coded him as being cognitively intact, having no mood issues or behaviors, requiring extensive assistance with activities of daily living and being edentulous (no natural teeth). The Care Area Assessment relating to dental needs dated 03/26/15 noted Resident #113 had no natural teeth, ate an appropriate diet, was free of mouth ulcers and was able to do his own mouth care. The Care Plan related to dental needs dated 04/01/15 had a goal for him to be free of infection, pain and bleeding. Interventions were to provide the diet as ordered, and observe for signs or symptoms of oral problems. On 10/13/15 at 9:34 AM, Resident #113 was observed to have no natural teeth and wearing no dentures. He stated at this time that the only thing he needed was teeth, that he had never had any dentures and wanted some. He further stated he had never seen the dentist while at this facility. Review of the medical record revealed no evidence that Resident #113 had seen a dentist	F 412	implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Resident was transported by facility to be seen by dentist on 10/27/2015. Social worker will follow up with resident and dentist to ensure dentures are obtained for Resident #113 if residents wishes to do so. 2. All current residents have the potential to be affected by the alleged deficient practice. Dental services contract is in place as of 06/01/2015 for on sight dental services. All residents will be assessed by RN Admin staff to determine dental service needs by 11/6/15. Assessments areas to include: mouth sores/lesions, red, bleeding or swollen gums, loose, broken or precarious teeth and whether or not the resident has dentures or their natural teeth. Appointments will be made for any residents determined to be in need of a dental consult or desires to be seen by a dentist. 3. MDS Coordinator will complete dental audit tool for all quarterly, annual, and admission assessments to assess for dental needs. The nursing staff were re-educated by DON regarding dental	

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F 412	Continued From page 7 since his admission. On 10/14/15 at 8:52 AM, the Social Worker (SW) was interviewed. SW stated a dentist came to the facility every 6 months. He stated that even residents without teeth were seen for evaluations. If a resident needed dental care prior to the next scheduled visit, SW stated he made arrangements to send the resident to the dentist outside of the facility. On follow up interview on 10/14/15 at 12:35 PM, SW stated the dentist was last in the facility on 07/15/15 but he could find no evidence that Resident #113 was seen by the dentist at that visit. SW stated that nursing should have documented Resident #113 was edentulous and let the SW know he needed to be seen. Interview with the MDS Nurse on 10/14/15 at 3:06 PM revealed that Resident #113 came without teeth but because he had no problems with pain or eating, she did not alert the SW of any special need to see the dentist. She stated she was not sure how the list was maintained for the dentist but if there is a special need for a resident to see the dentist due to things like pain she alerted SW so a special appointment could be scheduled. SW was interviewed again on 10/15/15 at 8:55 AM. He stated that he put all long term residents on the dental list and will put short term residents on the list if they express a need or have a need to see the dentist while at the facility. He stated Resident #113 started out as a short term resident and became a long term resident on 06/21/1/5. SW stated that he should have placed Resident #113 on the list to see the dentist at the last dental visit which occurred on 07/15/15. SW stated that according to his records, Resident	F 412	needs/assessments on 10/26/15. Social Worker was re-educated by NHA on 10/19/2015, regarding follow up with dentist after on-site visits, to ensure a plan is put in place for any resident not seen during the visit. Social History form that is completed on admission has been modified to include last Visit to Dentist and Dentist Name. The IDT (Interdisciplinary Team) will use data from this form to identify, upon admission, any resident in need of dental services and schedule dental appointments as appropriate. 4. Data obtained during audits will be analyzed by the NHA and Social Worker for patterns and trends and reported to QAPI committee bi monthly for 6 months; at which time the QAPI committee will evaluate the effectiveness of the interventions and will determine if further auditing is needed.	

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F 412	Continued From page 8 #113 was not seen by the dentist on 07/15/15. SW stated he was not aware Resident #113 was not seen by the dentist in July and could not explain how or why Resident #113 was not seen by the dentist. On 10/15/15 at 12:36 PM the Administrator stated the facility tried to make sure all residents saw the dentist when he came to the facility and she did not know what happened and how Resident #113 was missed. The facility provided information including a letter from the dentist dated 10/16/15 that stated the resident "was unavailable for a dental exam" when the dentist was onsite in July 2015. The letter did not explain the circumstances as to why Resident #113 was unavailable and the facility provided no other information as to the circumstances of the resident's unavailability during the dental visit to the facility on 07/15/15.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		11/12/15

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F 431	Continued From page 9 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to discard one expired punch card of hydrocodone/APAP, a narcotic pain medication, in 1 of 4 medication carts. The findings included: Resident #14 was admitted to the facility on 04/30/13 with diagnoses of arthritis, Alzheimer's disease and hypertension. The quarterly Minimum Data Set (MDS) dated 09/05/15 revealed Resident #14 was cognitively intact. Observations of the B Hall medication cart on 10/15/15 at 11:30 AM revealed one punch card of Hydrocodone/APAP 5-325 milligrams (mg) with an expiration date of 08/2015. During an interview conducted on 10/15/15 at 11:33 AM Nurse #1 stated the pharmacy checked the medication carts monthly for expired	F 431	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. On 10/16/2015, the Hydrocodone/APAP 5-325 milligrams (mg) with an expiration date of 08/2015 was removed from the medication cart and was returned to the pharmacy for proper disposal. MD was notified and order was received to discontinue the	

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F 431	Continued From page 10 medications and the nurses checked medication expiration dates before administering to residents. She stated she had not given hydrocodone/APAP 5-325 mg to Resident #14 and was not aware it had expired. An interview on 10/15/15 at 5:45 PM with the Director of Nursing (DON) revealed the pharmacy checked the medication carts monthly for expired medications. She further stated it was her expectation for each nurse to check the expiration date of the medication before administering it to the resident and discard the medication if it was out of date. During an interview conducted on 10/15/15 at 12:21 PM the Administrator stated the facility changed out all 4 medication carts for 4 new medication carts in 09/2015. She stated the pharmacy helped change out the medication carts and should have caught the hydrocodone/APAP that expired in 08/2015.	F 431	medication as Resident #14 had not required the use of the medication since 05/2015. 2. All residents has the potential to be affected by the same alleged deficient practice. An Audit was conducted by the DON of all the medication carts, no other residents were found to be affected by this deficient practice. 3. Measures put in place to ensure that the alleged deficient practice does not reoccur: The Director of Nursing conducted an in-service/reeducation for all Staff beginning on 10/26/2015 regarding medication storage and inspecting medications for expiration dates. The Medication Nurses will observe and inspect their medications carts every Sunday. The Unit Managers/Unit Coordinators will audit four residents medications for discontinued, expired, and soon to expire medications twice weekly for 4 weeks then twice monthly for 3 months. 4. The Director of Nursing will review the data obtained during facility audits; analyze the data and report patterns/trends to the QAPI committee every other month for 6 months. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	