STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 000	INITIAL COMMENTS IDR 12/21/15 resulted in a panel decision to lower F 323 from J to G and make it PNC because example 2 is deleted. The panel also recommended lowering F 520 from J to G. 1/14/15 CMS agreed with deletion of example 2 from F 323 and agreed with F 323 being PNC but left the tag at J rather than lower to G. CMS and SSA decided to deleted example 1 from F 520 as it cross referenced F 323 and lower the tag to a D.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by:	F 279		12/8/15

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

Electronically Signed | 12/01/2015

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 279	Continued From page 1 Based on record review and staff interview the facility failed to develop a care plan for the use of an antipsychotic medication for one of one sampled residents on antipsychotic medications. (Resident # 41) The findings included: Resident # 41 was readmitted to the facility after a hospitalization for mental status changes on 6/9/15. Discharge orders dated 6/9/15 included Seroquel (antipsychotic medication) 25 milligrams twice a day. Review of the Minimum Data Set (MDS) dated 6/16/15 for a Significant Change indicated Resident #41 was receiving antipsychotic medications in the last seven days. Review of the Care Area Assessments (CAAS) dated 6/16/14, for the CAA psychotropic drug use, revealed antipsychotic medication usage was checked, antianxiety and antidepressant were also checked. Review of "Analysis of findings:" Resident # 41 "is receiving 3 psychotropic meds. She had been on these long term. Her diagnosis to coorelate (sic) with these: depression and anxiety. She is at risk for side effects related to these medications. No side effects observed. Pharmacy review of meds monthly for effectiveness, possible dose reduction, side effects. Care Plan will be developed for this Care Area." Interview with MDS nurse coordinator on11/04/2015 at 3:05 PM revealed she missed the antipsychotic medication on the CAA. She would check the computer system to make sure the area was not care planned. Interview with MDS nurse coordinator on	F 279	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the accuracy of the facts alleged or conclusion set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code Section 12909 and C.F.R. 405 1907. F 279 For the resident cited: o A care plan for resident #41, addressing the use of antipsychotic medications, will be developed and added to the comprehensive care plan for this resident. For other residents at risk: o A report from our electronic medical record software (AHT), listing all residents with physician orders for antipsychotic medications, will be generated and the care plans for all residents identified will be reviewed to determine if their comprehensive care plan includes a plan of care for antipsychotic use. (Note: the review indicated that all residents receiving antipsychotic medications had a care plan for antipsychotic use.) System changes (new practices, new policies, new forms etc) o The facility practice in which nursing leadership reviews - each morning, 5 days a week - all physician orders received	

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F 279	Continued From page 2 11/04/2015 at 4:17 PM revealed she had not completed a care plan for psychotropic medications.	F 279	within the last 24 to □ 72 hours, will continue. A care plan for any resident identified as having new or changed orders for antipsychotic medications will developed. o The Nursing leadership, including MDS staff, will be re-educated regarding the daily physician order review, generating the monthly AHT report of residents on antipsychotic medications, and the process for developing care plans as the resident care needs change. How will we monitor for improvement: o Each week for the next 4 weeks, and then once each month for 12 months, a report from our electronic medical record software (AHT) showing all residents with physician orders for antipsychotic medications will be generated, and the care plans for those residents on antipsychotics will be audited to ensure they have a plan of care for antipsychotic use. o The results of the weekly and monthly audits of the care plans for all residents on antipsychotics will be presented to the Quality Management Team with QAPI at their monthly meeting for the next 12 months and the QMP with QAPI will modify the plan if the audits show an unfavorable trend.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		12/8/15

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F 280	Continued From page 3 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to update the care plan of 1 of 1 resident with current interventions due to the resident's refusals of a splinting device. (Resident #92). The facility failed to update the care plan for interventions of adaptive eating equipment for two of three residents (Residents #49 and 104). The findings included: 1. Resident #92 was admitted to the facility on 4/12/13. Diagnoses included Dementia and chronic contractures. Review of the Minimum Data Set (MDS), a quarterly, dated 8/18/15 indicated no behaviors	F 280	F 280 For the resident cited: o The care plan for resident # 92 will be revised to reflect current occupational therapy recommendations and resident wishes, for splinting devices. o The care plan will be updated for resident # 49 to include the need for a clear lap tray at every meal. o The care plan for resident #104 will be revised to include the need for a scoop dish to be provided at every meal. For other residents at risk: o Every resident will be screened by therapy staff for the potential need for	

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F 280	Continued From page 4	F 280		

were exhibited by Resident #92 and no rejection of care occurred during the assessment timeframe. Resident #92 had communication problems and had moderate impairment with memory. This MDS indicated Resident #92 had functional limitation in range of motion on one side of the upper extremity.

Review of the care plan with updates of 9/4/15 included a problem of skin breakdown risk due to impaired/decreased mobility. The update indicated a palm protector was to be used in the right hand while "awake" and a wash cloth was to be used in the right hand "while in bed."

Review of the therapy communication form dated 7/31/15 Resident #92 was referred to therapy on 7/31/15 by a nurse due to upper body/multi contractures of right arm/hand.

A telephone order dated 8/27/15 indicated occupational therapy was discontinued. The resident was to continue wearing the palm guard to maintain/prevent further contractures.

Record review of the nurses' notes for the dates of 8/29/15 9/2/15, 9/3/15 and 9/6/15 revealed Resident #92 refused to wear the palm guard, would remove the palm guard and the wash cloth from her hand. Documentation of one removal by the resident caused bruising over her eye due to pulling on the palm guard with force.

Observations on 11/04/2015 at 9:22 AM revealed Resident #92 was out of bed and seated in a wheelchair. The palm guard was on the tray table in front of the resident. Resident #92 held her right hand in a fist with her arm bent against her chest.

adaptive equipment. Those for whom the screen indicates a potential need for adaptive equipment will then be evaluated by therapy for actual need of adaptive equipment.
o If new adaptive equipment is required, or if existing adaptive equipment is to be continued, modified or discontinued per the resident evaluations, therapy will indicate their recommendations for adaptive equipment on physician orders.
o Care plans for all residents determined to need adaptive equipment will be revised to include new and or changed interventions.

System changes:
o A system for determining the need for adaptive equipment, communicating that need to the necessary departments, and updating the care plans and / or kardex, will be outlined.

The system is: Going forward, for each resident admitted to the facility or referred to therapy for screening, therapy will determine the need for adaptive equipment and will complete physician orders stating their recommendations. Therapy will also send an email to the dietary manager, dietician, MDS, and Administrator stating their recommendations. The dietary manager will then ensure the adaptive equipment is available for meals, the dietitian will monitor weight per facility policy, the MDS will update the care plan and kardex for the use of adaptive equipment, and the Administrator will ensure all steps are

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F 280	Continued From page 5 Interview with aide #1 on 11/3/15 revealed the resident refused the palm guard. The resident also takes the palm guard off at will. 2. Resident #49 was admitted to the facility on 9/2/14 with diagnosis diagnoses that included Alzheimer's disease, gastro-esophageal reflux disease without esophagitis, and macular degeneration. The most recent Minimum Data Set (MDS) assessment dated 8/21/15 revealed Resident #49 required extensive assistance with eating. The MDS further indicated resident #49 was cognitively impaired. Review of physician order dated 10/2/15 revealed Resident #49 to have lap tray placed on wheelchair for all meals to aid feeding. Review of Resident #49 nutritional evaluation dated 8/20/15 revealed a physician order for a clear lap tray as an adaptive dining device. Review of Resident #49 care plan last updated 9/10/15 indicated a "problem" of potential for weight loss related to leaving 25% of food uneaten at most meals. The goals included, Resident #49 would eat at least 50% of most meals served, and Resident #49 would maintain current weight or gain weight over the next 30 days. The approaches were not updated to include a clear lap tray at meals. Observation on 11/2/15 at 11:47 am revealed Resident #49 was eating her lunch from her meal tray which was placed on the dining table. The resident's meal cared reveled the resident needed to use a clear lap tray. No lap tray was observed during the meal. Observation of Resident #49 meal card revealed the resident needed to use a clear lap tray. No lap tray was observed during the meal.	F 280	followed timely. o When therapy records new recommendations for adaptive equipment on physician order forms, they will train the nursing staff caring for the resident, the SDC, and the appropriate nurse manager, on the proper use of the required adaptive equipment. o A list of the residents, and their needs, who require adaptive equipment is generated by the dietary manager whenever orders are added or changed and this list is available to staff who assist with meals. o The Therapy Department, Dietary, Registered Dietitian, and Nurse Leadership will be educated on the newly defined system for communicating the need for, and implementing use of, adaptive equipment. o Nursing staff will be educated on the correct use of adaptive equipment and the location of the list which details which residents need which equipment. How will we monitor for improvement: o Random audits of 20% of the residents with orders for adaptive equipment will be conducted each week for 4 weeks, and then monthly for 3 months. o The results of these weekly and monthly audits will be presented to the Quality Management Team with QAPI at their monthly meeting for the next 3 months and the QMT with QAPI will modify the plan if the audits show unfavorable trends and / or continued non-compliance.	

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F 280	Continued From page 6	F 280		

On 11/4/15 at 11:50 am, Resident #49 was observed to have her meal on a clear lap tray. The resident's milk and puree cake were observed on the dining table directly in front of the resident. Resident #49 was observed to reach over her lap tray to retrieve the items located on the dining table. The resident was observed having difficulty reaching over her lap tray to retrieve her milk and puree cake.

Observation on 11/4/15 at 8:51 am revealed Resident #49 to be eating in her room. The resident's meal tray was observed to be on her bedside table. The resident's meal card indicated the resident needed to use a clear lap tray. No lap tray was observed attached to Resident #49's wheelchair.

Observation of Resident #49 on 11/4/15 at 5:00 pm revealed Resident #49 eating at the dining table. Resident was being assisted with dining by nursing assistant (NA) #4. No clear lap tray was observed attached to Resident #49's wheelchair.

Interview with NA#4 assisting Resident #49 with dining on 11/4/15 at 5:00 pm stated Resident #49 sometimes had the clear lap tray and sometimes didn't. She stated she did not typically work with Resident #49 and was unaware of where the lap tray was.

Interview with the MDS coordinator on 11/5/15 at 9:23 am revealed dietary was responsible for updating care plans to include adaptive equipment. The therapist went to the dietician and the dietician included it on the care plan. Although she indicated she was not responsible the MDS coordinator indicated adaptive equipment should be included in the care plan.

Interview with the Dietician on 11/5/15 at 9:36 am revealed she was responsible for adding interventions to resident care plans that dealt with weights or chronic conditions regarding nutrition.

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F 280	Continued From page 7	F 280		

The dietician stated she would add interventions in regards to adaptive equipment. . The dietician implied that when the intervention included assistance was needed, she would consider that to include feeding assistance or feeding equipment. The type of equipment was placed on the resident's meal card but not on the care plan.
Interview with the Administrator on 11/5/15 at 8:20 am stated his expectation that recommendations for adaptive equipment be followed. He further indicated that his expectation was that adaptive equipment be used properly. Staff were to look at resident meal cards to ensure adaptive equipment needs were met. Staff were expected to communicate resident's needs or difficulty with recommended equipment to ensure therapy could put interventions into place.
3. Resident #104 was admitted to the facility on 4/1/15 with diagnoses that included, dementia without behavioral disturbance and dysphagia. The most recent Minimum Data Set (MDS) assessment dated 7/30/15 indicated Resident #104 required extensive assistance for eating. The MDS further indicate Resident#104 was cognitively impaired.
Review of Resident #104 physician order dated 10/1/15 revealed, "occupational therapy evaluation only with placement of scoop dish (adaptive dining plate) for independent self-feeding" and "use scoop dish with all meals. "
Review of Resident #104 occupational therapy (OT) evaluation dated 10/1/15 indicated Resident #104 had difficulty feeding himself. The evaluation stated a scoop dish was recommended for all meals.
Review of Resident #104's care plan updated 10/28/15 indicated a "problem" of being unable

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F 280	Continued From page 8	F 280		

to perform any of his own care, dressing, bathing, and toileting without extensive assistance of staff. Due to cognitive loss Resident #104 was unable to follow instructions consistently. The goal stated Resident #104 would be able to maintain his ability to feed himself. The approaches did not include the use of adaptive equipment.
Observation on 11/2/15 at 11:57 am revealed Resident #104 to be seated in front of a scoop dish. The scoop dish was observed to be turned backwards with the scoop side of the dish facing the resident. The scoop dish contained broccoli, mash potatoes and a bowl of soup. The bowl of soup was observed to be in the middle of the scoop dish. Resident #104 was observed eating the food around the bowl located in the center of the scoop dish. The resident was being provided assistance by the Assistant Director of Nursing (ADON).
Observation on 11/4/15 at 8:27 am revealed Resident #104 to be assisted with dining by nursing assistant (NA) #6. NA#6 was observed to have Resident #104's meal tray directly in front of her on a bedside table. Resident #104 was observed to be to the left of staff. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the staff
Interview with the MDS coordinator on 11/5/15 at 9:23 am revealed dietary was responsible for updating care plans to include adaptive equipment. The therapist went to the dietician and the dietician included it on the care plan. Although she indicated she was not responsible the MDS coordinator indicated adaptive equipment should be included in the care plan.
Interview with the Dietician on 11/5/15 at 9:36 am revealed she was responsible for adding interventions to resident care plans that dealt with weights or chronic conditions regarding nutrition.

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F 280	Continued From page 9 The dietician stated she would add interventions in regards to adaptive equipment. The dietician implied that when the intervention included assistance was needed, she would consider that to include feeding assistance or feeding equipment. The type of equipment was placed on the resident's meal card but not on the care plan. Interview with the Administrator on 11/5/15 at 8:20 am stated his expectation that recommendations for adaptive equipment be followed. He further indicated that his expectation was that adaptive equipment be used properly. Staff were to look at resident meal cards to ensure adaptive equipment needs were met. Staff were expected to communicate resident's needs or difficulty with recommended equipment to ensure therapy could put interventions into place.	F 280		
F 323 SS=J	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 observation, record review and staff interview the facility failed to have two persons perform transfers for 1 of 4 sampled residents (Resident #117). The findings included:	F 323	Past noncompliance: no plan of correction required.	1/14/16

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F 323	Continued From page 10	F 323		

Resident #117 was admitted to the facility on 4/1/15 with diagnoses that included Heart Failure, atrial fibrillation, dysphagia, and anxiety disorder.

Review of the admission minimum data set (MDS) assessment dated 6/8/15 revealed Resident #117 required extensive assistance with bed mobility and transfer with the use of 2 staff. The MDS further indicate Resident #117 was moderately cognitively intact.

Review of the care area assessment (CAA) dated 4/8/15 revealed Resident #117 was currently non ambulatory, dependent on staff for transfer with using maxi lift (total mechanical lift) by nursing assistants (NA). The CAA stated, "Therapy was working on standing transfers but report (Resident #117) was not able."

Review of Resident #117 care plan updated 6/8/15 revealed no care plan in regards to transfers.

Review of the Kardex (electronic information used for a resident care guide) indicated Resident #117 required 2 + staff for transfers.

Review of Resident #117 incident report dated 7/29/15 revealed Resident #117 had a fall in his room which resulted in injury. The narrative of the incident stated, "Both hall NAs (nursing assistants) (NA#1 and NA#2) were in Resident #117's room. NA#1 and NA#2 had Resident #117 on the total mechanical lift. The right upper body strap came undone and Resident #117 fell about 1-2 feet to the floor. " The incident report continued with Resident #117 had approximately 7cm (centimeters) in diameter round knot on right side of his head and a small abrasion under the

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 323	Continued From page 11	F 323		

knot on back of his bead. Trace amounts of blood were noted. The medical director was notified and ordered Resident #117 to the emergency room for evaluation and treatment. The immediate post-incident action stated, "Investigating why lift pad came undone and reeducated staff on proper ways to hook lift pad to lift." The narrative of investigation stated, "Both the lift and the sling were in working order. Re-education with all staff on proper use of mechanical lift and safe transfer procedure. Random audits of transfer begun. (Resident #117) is a hands on two person transfer." Their investigation indicated that all staff were re-educated on the mechanical lift with the use of 2 people on 7/30/15.

Review of physician order dated 7/29/15 stated send Resident #117 to the emergency room for evaluation and treatment of post fall.

Hospital discharge summary dated 7/30/15 indicated Resident #117 was sent from the nursing home for a fall. Resident #117 had a CT (x-ray procedure) and magnetic resonance imaging (MRI) of the neck which showed a C2 fracture. The discharge summary further indicated resident #117's left shoulder x-ray showed he had a dislocated shoulder.

Review of Resident #117's significant change MDS assessment dated 8/7/15 revealed a significant change from Resident #117's 6/8/15 MDS assessment for activities of daily living (ADLs). The areas of change indicated resident went from extensive assistance with one person assistance to total assistance with the use of 2 people in the areas of locomotion. Resident #117 went from total dependence with one person

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 323	Continued From page 12	F 323		

physical assistance to total dependence with two person assistance in the area bathing self-performance. Resident #117 went from not steady with balance (only able to stabilize with staff assistance) to the activity did not occur with moving from seated to standing position. Resident #117 went from not steady (only able to stabilize with staff assistance) to the activity did not occur in the areas of balance: moving on and off the toilet.

Review of Resident #117's physician order dated 9/4/15 stated may discontinue cervical collar on 9/9/15.

Interview with NA#1 on 11/4/15 at 4:27pm stated on 7/29/15, she and NA#2 were in the process of completing their last rounds for their shift. NA#1 and NA#2 had to lay down Resident #117 and his roommate that were both 2 person assist/transfer. NA#1 indicated she was in the process of providing care to Resident #117's roommate when NA#2 went ahead and hooked Resident #117's lift pad up to the mechanical lift. While NA#2 was taking Resident #117 up in the total mechanical lift one of the four hooks from the lift pad came undone. NA#1 stated the hook that goes around Resident #117's right shoulder had come undone. As a result Resident #117 went backwards and hit his head on the floor. NA #1 indicated she told NA#2 to stay with Resident #117 so NA#1 could get assistance. The Assistant Director of Nursing (ADON) assisted with getting Resident #117 off the floor. NA#1 revealed she and NA#2 were supposed to have 2 people with the total mechanical lift when hooking the resident up by the lift pad. NA#2 was the only staff transferring Resident #117 with the mechanical lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 13	F 323		

NA#2 was unavailable for interview.
Interview with the assistant director of nursing (ADON) on 11/5/15 at 7:48am revealed she was approached by NA#1 that communicated Resident #117 had fallen out of the mechanical lift. The ADON indicated she went into Resident #117's room and observed Resident #117 on the floor with the total mechanical pad underneath him. Both leg straps were hooked and one shoulder strap of the lift pad was hooked. The hook for the right shoulder strap of the lift pad was observed to be unhooked. The ADON stated she lowered Resident #117 the rest of the way to the floor due to his body still being slightly propelled by the connected lift pad. The ADON stated she rolled Resident #117 to see the back of his head to determine where the blood was coming from. Resident #117 was upset as evidenced by cursing at nursing staff and stated he said he hurt all over. The ADON stated when she questioned the 2 NAs about what had occurred it was communicated that NA#1 was providing care to Resident #117's roommate and NA#2 was putting Resident #117 in the bed also. The NAs stated they both were in the room but both were not with the lift at the same time for 2 person transfer. ADON revealed staff were instructed during training to use 2 people for a total lift. Even if one NA was doing all the work the other NA was to ensure that the hooks clicked into place (when you pull it into place they click). The ADON stated "we terminated (NA#2) following the incident for not following company policy."
Interview with the Administrator on 11/5/15 at 8:20am revealed he was made aware of the incident involving Resident #117's fall on 7/29/15. Upon an internal investigation it was discovered that NA#1 was helping Resident #117's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 14	F 323		

roommate and NA#2 took it upon herself to transfer Resident #117 even though he needed the assistance of two persons. The Administrator indicated that the internal investigation and inspection of the mechanical lift revealed no mechanical error with the lift. The Administrator described the lift pad as having slings that had tabs that fastened to the total mechanical lift. The tabs were described as hook and eye tabs. The Administrator stated when "you pull down on the tab it makes a distinct pop sound that indicates it is in place and properly hooked." The Administrator stated NA#2 was terminated as a result of not following company guidelines as it related to operating the lift with 2 people.
Resident #117 was described by the Administrator as a large man who required 2 staff to ensure his safety during a transfer utilizing the mechanical list. The Administrator stated it was his expectation that staff operated the mechanical lift properly and the resident was safe during the transfer. It was further his expectation that staff followed training and guidelines when transferring any resident.
Corrective action for resident affected.
Immediate care of the injury was performed, the attending physician and family member were notified. The resident was sent to the hospital where he remained in observation for 24 hours for a fracture at C2. This was completed by the charge nurse on 7/29/15.
The lift and lift pad were removed from service until they could be inspected for mechanical problems. None were found and the lift was put back into service. This was completed by the administrator and maintenance director on 7/29/15.
A full investigation into the root cause of this fall with injury was conducted: The findings showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

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CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 323	Continued From page 15	F 323		

the resident was care planned for a 2 person assistance, and this information was also on the SmartChart (the instructions for providing care that the CNAs (nursing assistants) and Nurses see each time they provide ADL assistance, incontinence care, etc.) However, one CNA attempted a transfer with a mechanical lift with resident #117 by herself. She was suspended immediately after the fall on 7.29.15. The root cause analysis showed there was no fault with the lift or lift pad, and that the root cause of the accident was the CNA, who failed to follow facility procedure. The CNA was terminated, without ever returning to work. This was completed by the administrator, and director of nursing on 7/29/15.
Upon resident #117's return to the facility, a full assessment was attempted, although he refused a skin check, saying he was fine. This was completed by the charge nurse on 7/30/15.
The care plan was revised to include a neck collar and new pain medications. Use of a mechanical lift for transfers was added to the care plan, as was the need for a 2 person assistance. This was completed by the MDS Coordinator on 8/2/15.
Corrective action for residents with the potential to be affected
Observations of all other residents who required mechanical lifts for transfers were made. No other transfers were done inappropriately (using proper technique and following facility procedure for knowing where to look to find the level of assistance needed (1 person or two persons).This was completed by the Staff Development Coordinator on 7/29/15.
All mechanical lifts and pads were removed from service until they could be inspected to identify mechanical problems or wear/tear concerns. All lifts and lift pads passed this inspection and were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 16	F 323		

put back into service. This was completed by the administrator and maintenance director on 7/29/15.
The care plans and SmartChart information for all residents who were transferred using a mechanical lift, were reviewed to ensure the care plan for the level of assistance (1 or two person) was correct, and the SmartChart information matched the care plan instructions. This was completed by the MDS Coordinator on 7/30/15.
Measures/systems that were put into place to ensure the deficient practice does not occur again.
Direct care staff were educated on the proper lift procedures, including the need for 1 or 2 persons to assist. The hand out was entitled "Steps to Safe Transfer". The inservice, and the handout stated that "If a resident requires 2 person assist, 2 staff members must be present during the entire lift procedure". This was completed by the Staff Development Coordinator on 7/29/15.
Direct care staff were not allowed to transfer any resident until they had been educated which included a return demonstration.
Any employee who failed to pass the return demonstration was not allowed to transfer any resident using a mechanical lift until he/she passed the return demonstration. None failed to pass.
New employees are trained on proper procedures for transferring with mechanical lifts, including return demonstration, during their orientation period and annually. Going forward, spot audits will be conducted on all new direct care staff x 3 during their first 3 weeks of employment.
Validation of the corrective action plan was conducted on 11/6/15. The inservice information was reviewed which included the use of the total lift, safety precautions to take, ensure the clip

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

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CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 323	Continued From page 17 "clicks" , and where to find the information regarding how many staff required to transfer a resident. Direct care staff and nurses were interviewed concerning the inservice information. Interviews were conducted with administrative staff regarding the plan for education for staff not currently working. A plan was in place for the weekend to ensure staff would receive inservice training before working. Observation of direct care staff using a mechanical lift for a total care resident revealed no resident safety concern during transfer.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to follow physician orders and therapy recommendations for 2 of 3 sampled residents (Resident #49 and Resident #104) who required adaptive dining equipment. The findings included: 1. Resident #49 was admitted to the facility on 9/2/14 with diagnosis diagnoses that included Alzheimer ' s disease, gastro-esophageal reflux disease without esophagitis, and macular degeneration. The most recent Minimum Data Set (MDS) assessment dated 8/21/15 revealed Resident #49 required extensive assistance with eating. The MDS further indicated resident #49 was cognitively impaired. Review of physician order dated 10/2/15 revealed	F 369	F 369 For the resident cited: o A clear lap tray will be provided to resident # 49 at every meal. o A scoop dish will be provided to resident #104 at every meal and will be used appropriately. For other residents at risk: o Every resident will be screened by therapy staff for the need for adaptive equipment and any resident for whom the screen indicated a potential need for adaptive equipment will evaluated by therapy staff for actual need. Therapy will record their recommendations on	12/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 369	Continued From page 18 Resident #49 to have lap tray placed on wheelchair for all meals to aid feeding. Review of Resident #49 nutritional evaluation dated 8/20/15 revealed a physician order for a clear lap tray as an adaptive dining device. Review of Resident #49 care plan last updated 9/10/15 indicated a "problem" of potential for weight loss related to leaving 25% of food uneaten at most meals. The goals included, Resident #49 would eat at least 50% of most meals served, and Resident #49 would maintain current weight or gain weight over the next 30 days. The approaches were not updated to include a clear lap tray at meals. Observation on 11/2/15 at 11:47 am revealed Resident #49 was eating her lunch from her meal tray which was placed on the dining table. The resident ' s meal cared reveled the resident needed to use a clear lap tray. No lap tray was observed during the meal. Observation of Resident #49 meal card revealed the resident needed to use a clear lap tray. No lap tray was observed during the meal. On 11/4/15 at 11:50 am, Resident #49 was observed to have her meal on a clear lap tray. The resident ' s milk and puree cake were observed on the dining table directly in front of the resident. Resident #49 was observed to reach over her lap tray to retrieve the items located on the dining table. The resident was observed having difficulty reaching over her lap tray to retrieve her milk and puree cake. Observation on 11/4/15 at 8:51 am revealed Resident #49 to be eating in her room. The resident's meal tray was observed to be on her bedside table. The resident's meal card indicated the resident needed to use a clear lap tray. No lap tray was observed attached to Resident #49's wheelchair.	F 369	physician order forms if new adaptive equipment is required or if existing adaptive equipment is to be continued, modified or discontinues. o Care plans for all residents determined to need adaptive equipment will be revised to include new and or changed interventions. System changes (new practices, new policies, new forms etc) o A system for determining the need for adaptive equipment, communicating that need to the necessary departments, and updating the care plans and / or kardex, will be outlined. The system is: Going forward, for each resident admitted to the facility or referred to therapy for screening, therapy will determine the need for adaptive equipment and will complete physician orders stating their recommendations. Therapy will also send an email to the dietary manager, dietician, MDS, and Administrator stating their recommendations. The dietary manager will then ensure the adaptive equipment is available for meals, the dietitian will monitor weight per facility policy, the MDS will update the care plan and kardex for the use of adaptive equipment, and the Administrator will ensure all steps are followed timely. o When therapy records new recommendations for adaptive equipment on physician order forms, they will train the nursing staff caring for the resident, the SDC, and the appropriate nurse	

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 369	Continued From page 19 Observation of Resident #49 on 11/4/15 at 5:00 pm revealed Resident #49 eating at the dining table. Resident was being assisted with dining by nursing assistant (NA) #4. No clear lap tray was observed attached to Resident #49's wheelchair. Interview with NA#4 assisting Resident #49 with dining on 11/4/15 at 5:00 pm stated Resident #49 sometimes had the clear lap tray and sometimes didn't. She stated she did not typically work with Resident #49 and was unaware of where the lap tray was. During an interview and observation with the therapy director on 11/4/15 at 5:07 pm revealed Resident #49 was to have a clear lap tray attached to her wheelchair at each meal and did not have it. 2. Resident #104 was admitted to the facility on 4/1/15 with that included, dementia without behavioral disturbance, and dysphagia. The most recent Minimum Data Set (MDS) assessment dated 7/30/15 indicated Resident #104 required extensive assistance for eating. The MDS further indicate Resident#104 was cognitively impaired. Review of Resident #104 physician order dated 10/1/15 revealed, "occupational therapy evaluation only with placement of scoop dish (adaptive dining plate) for independent self-feeding" and "use scoop dish with all meals." Review of Resident #104 occupational therapy (OT) evaluation dated 10/1/15 indicated Resident #104 had difficulty feeding himself. The evaluation stated a scoop dish was recommended for all meals. Review of Resident #104's care plan updated 10/28/15 indicated a "problem" of being unable to perform any of his own care, dressing, bathing, and toileting without extensive assistance of staff.	F 369	manager, on the proper use of the required adaptive equipment. o A list of the residents, and their needs, who require adaptive equipment is generated by the dietary manager whenever orders are added or changed and this list is available to staff who assist with meals. o A new program, Dining Room Monitor, will be initiated. In this program leadership staff will rotate being present in the dining room for each meal. They will observe the meal service, looking for appropriate use of adaptive equipment. o The Therapy Department, Dietary, Registered Dietitian, and Nurse Leadership will be educated on the newly defined system for communicating the need for, and implementing use of, adaptive equipment. o Nursing staff will be educated on the correct use of adaptive equipment and the location of the list which details which residents need which equipment. o Leadership staff will be educated on the Dining Room Monitor program. How will we monitor for improvement: o Random audits of 20% of the residents with orders for adaptive equipment will be conducted each week for 4 weeks, and then monthly for 3 months. o The results of these weekly and monthly audits will be presented to the Quality Management Team with QAPI at their monthly meeting for the next 3 months and the QMT with QAPI will modify the plan if the audits show unfavorable trends or continued	

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 369	Continued From page 20	F 369		

Due to cognitive loss Resident #104 was unable to follow instructions consistently. The goal stated Resident #104 would be able to maintain his ability to feed himself. The approaches did not include the use of adaptive equipment.
Observation on 11/2/15 at 11:57 am revealed Resident #104 to be seated in front of a scoop dish. The scoop dish was observed to be turned backwards with the scoop side of the dish facing the resident. The scoop dish contained broccoli, mash potatoes and a bowl of soup. The bowl of soup was observed to be in the middle of the scoop dish. Resident #104 was observed eating the food around the bowl located in the center of the scoop dish. The resident was being provided assistance by the Assistant Director of Nursing (ADON).
Observation on 11/4/15 at 8:27 am revealed Resident #104 to be assisted with dining by nursing assistant (NA) #6. NA#6 was observed to have Resident #104's meal tray directly in front of her on a bedside table. Resident #104 was observed to be to the left of staff. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the staff
Interview on 11/4/15 at 8:27 am with NA#6 revealed Resident #104 was able to independently feed himself. The dietary department kept staff abreast through monthly meetings in which adaptive equipment and dietary concerns were discussed. NA#6 indicated the dietary department instructed her on how the adaptive equipment was used.
Observation on 11/4/15 at 11:41 am revealed Resident #104 being assisted with dining by the ADON. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the resident. Resident was observed to be holding a piece of cake in his right hand and a

non-compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 369	Continued From page 21 dinner roll with his left hand. Observation on 11/4/15 at 5:00 pm revealed Resident #104 being assisted with dining by the ADON. The scoop dish was observed to be turned backwards with the scoop side of the bowl facing the resident. During an observation of Resident #104 on 11/4/15 at 5:07 pm and interview with the therapy director revealed Resident #104s scoop dish was not being used appropriately. The scoop portion of the dish should be facing away from the resident. Interview with the ADON on 11/5/15 at 8:02 am revealed she was not trained on the use of the scoop dish. She was unaware of which direction the scoop dish was to be placed. Interview with the Administrator on 11/5/15 at 8:20 am stated his expectation that recommendations for adaptive equipment be followed. He further indicated that his expectation was that adaptive equipment be used properly. Staff were to look at resident meal cards to ensure adaptive equipment needs were met. Staff were expected to communicate resident's needs or difficulty with recommended equipment to ensure therapy could put interventions into place.	F 369		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSON RIDGE ROAD ELKIN, NC 28621

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F 371	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean and air dry 3 of 15 pans stored for use; maintain and clean 1 of 1 fan in operation in the kitchen area and maintain a temperature of 41 degrees Fahrenheit (F) or below in 1 of 3 nourishment refrigerators. Findings included: 1. On 11/04/2015 at 9:41 AM three pans were observed on the storage rack that had food particles and moisture both on the interior surfaces and the bottom of the pans. The other 12 pans were clean and dry. The Dietary Manager was present at the time the pans were viewed. He immediately set aside the pans to be rewashed. During an interview on 11/05/2015 at 10:08 am the Dietary Manager stated that the pans should have been properly cleaned and air-dried. He stated that he removed the excess pans after the observation 11/04/2015 to allow for more drying room and that the drying rack would be extended. He stated that he expects the pans to be clean and dry when stored. 2. On 11/04/2015 at 9:41 AM a fan located in the dishwashing area on the clean dishes side was observed blowing toward the dishwasher and drying racks. Lint had coated the wire covering of the fan with one string of lint dangling off the bottom right side of the fan covering. The Dietary Manager was present for the observation. The Dietary Manager shared a job description for a dietary aide in which the fan cleaning was outlined to be once a week on Saturday and/or Sunday. The dietary manager was interviewed 11/05/2015 at 10:08 am. When asked how long it had been since the fan was cleaned he replied,	F 371	F 371 For the resident cited: oNo resident cited. For other residents at risk: o System changes affect all residents. System changes: o Two new drying racks were purchased so there would be enough space to air dry all pans. o The floor fan was removed from use, permanently. o The supplement refrigerator located in the medication room at station 1 had become unplugged, causing the temperature within the unit to rise. The refrigerator was plugged back into the wall outlet. o All supplement refrigerators will checked each shift by nursing staff and any refrigerators that are not within acceptable range will be put out of commission until they are repaired. o Dietary staff will be trained on cleaning and drying of pans. o Nursing will be trained on monitoring / recording refrigerators temps for refrigerators located in the medication room, and on what to do if a refrigerator temp is outside of acceptable temps. The nursing staff will also trained on which outlets to avoid when charging medication carts, lifts, laptops.	

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	345095	A. BUILDING _____ B. WING _____	11/06/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 "Obviously more than a week." 3. On 11/05/2015 at 3:31 pm the refrigerator for nutritional supplements located in the medication room for 100-300 halls was found to be unplugged. The temperature was observed to be 68 degrees F. The shelves and the items inside felt to the touch to be at room temperature. The refrigerator contained 10 nutritional shakes and 4 supplemental puddings. LPN #1 was present for the observation. The ADON was notified and interviewed immediately following the observation. When she was told that the supplement refrigerator had been unplugged, her response was, " Again? " She immediately went into the medication room plugged in the refrigerator and told staff to throw out the supplements that were not shelf stable. Registered Dietician #1 was on the floor at the time of the observation. She stated that the only items in the refrigerator that were not shelf stable were the Mighty Shakes. She further stated that the other items were only refrigerated for taste. A review of the temperature log labeled as the nutritional supplement refrigerator for the medication room indicated that the temperature was noted to be at 60 degrees F on 11/5/2015 at 1:00 AM. There was no notation to indicate that staff had attempted to correct the temperature at that time.	F 371	How will we monitor for improvement: o An audit will be conducted 5 times a week for 4 weeks, and then once per month for 3 months, of all pans after clean-up of meals, to ensure the pans have been completely cleaned and air dried before being stored. o Random review of the temperature logs of the supplement refrigerators located in the medication rooms will be conducted 5 times per week for 4 weeks, and then once per month for 3 months. o The audits of the pans and the daily temperature logs of the supplement refrigerators will be reviewed by the Quality Management Team with QAPI each month for the next 3 months and the QMT with QAPI will modified the plan if the audits of pan cleanliness / air dried, and supplement refrigerators show unfavorable trends and / or continued non-compliance.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		12/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	11/06/2015

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F 520	Continued From page 24 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 10/09/2014 in order to achieve and sustain compliance. The facility also had a deficiency on failure to develop comprehensive care plans (F279) on the recertification survey of 10/09/2014 and, again on the current recertification survey. The facility had a deficiency on failure to update comprehensive care plans (F280) on the recertification survey of 10/09/2014 and the current recertification Survey. The findings included: 1. This tag is cross referenced to F 279: Based on record review and staff interview the facility	F 520	F 520 For the resident cited: o No specific resident cited. For other residents at risk: o All residents are affected by the system changes below. System changes: o The Quality Management (QM) with QAPI Team will be re-educated to ensure they function according to facility practice and re prompt at identifying unfavorable variances and trends, investigating	

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F 520	Continued From page 25 failed to develop a care plan for the use of an antipsychotic medication for one of one sampled residents on antipsychotic medications. (Resident # 41) 2.This tag is cross referenced to F 280: Based on observations, record review and staff interview, the facility failed to update the care plan of 1 of 1 resident with current interventions due to the resident's refusals of a splinting device. (Resident #92). The facility failed to update the care plan for interventions of adaptive eating equipment for two of three residents (Residents #49 and 104). An interview was conducted on 11/05/2015 3:36 PM with the facility's Staff Development Coordinator (SDC) which revealed that the SDC was responsible for being the contact person for the facility's Quality Assessment and Assurance (QAA) committee. She did note that she was new to the position and was not aware of the previous citations that the facility had received or the need for continued follow up to prevent future citations in the same previously cited areas. The SDC stated that the QAA committee met generally one time a month, but definitely met quarterly. Committee members included the Medical director, facility administrator, registered dietician, the activity coordinator, social worker, the DON and SDC as well as other (ancillary staff) staff members as able to schedule attendance. The SDC did reveal log books, in services and follow up on previous plans of correction follow up, and also a log book including meeting minutes for current QAA issues being addressed which included weight loss, wound management, and investigative procedures for root causes and analysis of the previously mentioned areas.	F 520	issues, and initiating / revising plans of actions, PIPs and PoCs. The team includes: a. Administrator b. Director of Nursing c. Medical Director d. Assistant Director of Nursing e. Quality Manager / Staff Development f. Wound Nurse (removed from QM with QAPI Team on 11.18.15 g. Activity Director h. Therapy Director i. Maintenance Director (removed from QM with QAPI Team on 11.18.15) j. Social Work (vacant position) k. Dietary Manager o The training for the QM with QAPI Team will be conducted using the "Orientation for the Quality Manager" checklist, plus additional information on these items a. Policies related to Quality Management and QAPI. b. Which indicators to track and trend and how to read the charts and graphs. c. How to determine if an action plan is needed due to unfavorable trends, exceeded thresholds. d. How to conduct investigations into incidents / events. e. How to document investigations. f. How to track incidents per facility and per resident. g. How to hold their Quality Management with QAPI Team meetings each month using the agenda that requires they review all action plans, indicators, incident trends etc. h. How to initiate and follow through on	

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F 520	Continued From page 26	F 520	action plans, PIPs, and PoCs to ensure the plans are effective. o To monitor for repeat deficiencies related to supervision to prevent accident / hazards, incident reports are reviewed by the Quality Management with QAPI team members during the IDT morning meeting, 5 days a week, every week, for 12 months. Trends for random and systemic errors for individual residents, and / or for the facility in general, will be identified, root cause analysis will be conducted, and action plans for random errors will be developed and implemented to correct the potential for accidents / hazards. A full PIP, using FOCUS PDCA which includes root cause analysis, will be undertaken if the concern is a system concern rather than a random error. o To eliminate repeat deficiencies related to producing comprehensive care plans, (F 279), each time a comprehensive assessment is completed, the care plan will be reviewed by the ITD and Director of Nursing to ensure all care area triggers were considered for the need for a care plan. This will continue for 12 months. o To eliminate repeat deficiencies related to updating care plans, our morning clinical meeting agenda was modified to include the item, update care plan and SmartChart as indicated. The staff will update the care plan and SmartChart, daily, as physician orders and or dietary / therapy recommendations indicate changes in therapy, medications, treatments, adaptive equipment etc.	

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F 520	Continued From page 27	F 520	How we will monitor for improvement: o Incidents will be tracked monthly for 12 months to identify unfavorable trends and system errors / concerns. The Quality Management (QM) with QAPI Team will review the tracking reports monthly and the plan will be modified if the QM with QAPI team identifies system concerns, and / or if unfavorable trends or continued non-compliance is identified. o Random audits of the medical records of 10% of all skilled residents will be conducted each month for 3 months, and quarterly for 9 months, to ensure the residents current condition, and the care being given, is reflected in the care plan. These audits will be presented to the Quality Management with QAPI Team each month at their monthly meeting and the QM with QAPI team will modify the plan if unfavorable trends or continued non-compliance is identified.	