| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345173 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EMERALD HEALTH & REHAB CENTER | 54 RED MULBERRY WAY LILLINGTON, NC 27546 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 242 SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff and resident interviews, the facility failed to offer an alternate food choice to 1 of 1 residents who stated they did not like what was on their plate (Resident #109).<br><br>Findings included:<br><br>Record review indicated Resident #109 was admitted to the facility on 12/02/2017 with admission diagnoses which included Heart Failure, Reflux Disease, Diverticulosis of Large Intestine, Dysphagia and Esophagitis.<br><br>Review of the resident's admission Minimum Data Set (MDS) dated 12/09/2017 indicated the resident had no cognitive impairment. The MDS also indicated the resident was independent for eating with setup help only. | F 242 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>1a. Interim Dietary Manager interviewed Resident #109 on 2/15/2017 for her likes and dislikes and made corrections to resident's meal ticket as appropriate.<br>1b. Nursing Assistant #1 was in-serviced by DON on 2/15/2017 on listening closely and making sure that the resident is ok with meal before leaving the residents side.<br>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:<br>2a. Interim Dietary Manager interviewed facility residents as appropriate for their likes/dislikes and made corrections to | 3/16/17 |

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

Electronically Signed | 03/10/2017

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| F 242 | Continued From page 1<br>The resident was observed and interviewed in her room on 02/15/2017 at 11:45 AM. The resident stated she had lost weight recently due to serious stomach issues in which she was hospitalized several times. She stated the food in the facility was good sometimes and not at other times. She stated the facility gave menus to fill out which had choices. She further stated if she told staff she didn't like something on her tray, sometimes they offered something else, and sometimes, they didn't. During the interview, Nursing Assistant (NA) #1 entered the room and delivered the resident's lunch tray. The NA placed the tray in front of the resident on a table. When the NA removed the plate lid, the resident stated "I don't like ham" (which was on the plate). The NA continued to chat with the resident about all the good things on the plate and then exited the room and began passing out trays to other residents on the unit. The NA did not offer an alternate food choice before she exited the room. When the resident was asked what she would do about the ham on her plate, she stated "I will eat it. I have to eat."<br><br>On 02/15/2017 at 12:04 PM, NA#1 was interviewed. When asked what she did if a resident stated they did not like what was on their tray, the NA stated she offered them another option. When asked about the incident with Resident #109 and the statement the resident made about not liking the ham on her plate, the NA stated she did not hear the resident say that.<br><br>On 02/15/2017 at 12:08 PM, the facility Director of Nursing (DON) was interviewed. The DON stated the expectation was when residents stated they did not like what was being served, staff should offer other options. | F 242 | resident's meal tickets as appropriate.<br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:<br>3a. Facility staff was in-serviced by DON/designee on listening to residents closely and make sure that the resident is ok with the meal before leaving the residents side. Education will be provided at time of orientation for new employees.<br>3b. On admission, Dietary Manager/designee will interview residents so that food likes/dislikes may be documented on meal ticket.<br>3c. Staff educated by DON/designee that an alternate meal is always available if resident does not like/want the menu selection.<br>4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:<br>4a. Facility DON/designee will audit 4 random residents per week for 12 weeks to make sure that their likes/dislikes are correct on the meal tickets and if they were served a dislike, they were offered something else to replace offered meal.<br>4b. If residents likes/dislikes are found to be incorrect, Interim Dietary Manager/designee will interview facility residents and make corrections on meal tickets.<br>4c. If residents where served a dislike and was not offered a substitute, facility staff will be re-in-serviced by DON/designee on listening to resident closely and make sure that the resident is ok with the meal before leaving the residents side. | |

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| F 242 | Continued From page 2 | F 242 | 5. Results of the audits will be taken to QA&A meeting monthly for 3 months. | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>(b) Comprehensive Assessments<br><br>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br><br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the<br>care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must | F 272 | | 3/16/17 |

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| F 272 | Continued From page 3<br>include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br><br>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility failed to accurately assess one of three residents reviewed for range of motion (Resident #107).<br>Findings included:<br><br>A review of the medical record revealed Resident #107 was admitted 3/10/2015 with diagnoses of muscle weakness, schizoid personality disorder, cervical myelopathy (compression of the spinal cord in the neck) and dementia without behaviors.<br><br>The annual Minimum Data Set (MDS) dated 11/8/2017 noted the resident was moderately impaired for cognition and needed extensive assistance for dressing, eating and personal hygiene. The MDS indicated under section G0400 Functional Limitation in Range of Motion, A. Upper extremity (shoulder, elbow, wrist, hand) = 0 no impairment. The Care Area Assessment (CAA) did note an area of concern about Activities of Daily Living (ADL) Function/Rehabilitation Potential and this area went to care plan. | F 272 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>1a. Resident #107 MDS section G0400 was corrected on 2/16/2017.<br>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:<br>2a. A contracture audit was completed by MDS Coordinator/designee on facility residents to verify that MDS section G0400 is accurate and reflects the residents ROM. Corrections would be made to the MDS if appropriate.<br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:<br>3a. MDS Coordinator will be in-serviced by Regional Reimbursement Specialist on how to properly assess and code section G0400. Education will be provided at time or orientation for new MDS employees. | |

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| F 272 | Continued From page 4<br>The care plan dated 1/11/2017 noted a focus of alteration in musculoskeletal status related to contracture of bilateral hands. The goal was the Resident will remain free of injuries or complications related to contractures. Interventions included: Plan activities during optimal times when pain and stiffness is abated. Call light within reach. Medications as ordered and monitor and document side effects and effectiveness. Therapy as ordered. Monitor/document/report to MD complications related to contractures. Monitor for decreased range of motion.<br><br>On 2/13/2017 at 10:30 AM, Resident #107 was observed to be wearing bilateral hand splints. Hands were observed to be clean with no cracked or open areas. Fingernails were clean. Resident #107 stated she could not use her hands at all and she wore the hand splints at all times except when in the shower.<br><br>On 2/16/2017 at 11:00 AM in an interview, the MDS Nurse was asked about the coding of G0400 the range of motion in the extremities. The MDS Nurse indicated she did not remember if Resident #107 was coded wrong or not, that she did so many assessments, she could not remember. The MDS Nurse opened the MDS on her computer to the annual assessment and stated "the upper extremity is coded no impairment, does she have an impairment?"<br><br>On 2/16/2017 at 11:15 AM in an interview, the Director of Nursing (DON) stated the expectation was the MDS would be coded correctly. | F 272 | 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>4a. Facility DON/designee will audit 4 random MDS per week for 12 weeks for accuracy of section G0400.<br>4b. If audits shows incorrect coding of section G0400, facility will re-audit facility residents to verify that MDS section G0400 is accurate and reflects the residents ROM.<br>4c. MDS Coordinator will be re-in-serviced on proper assessing and coding of the MDS section G0400 by Regional Reimbursement Specialist.<br>5. Results of the audits will be taken to QA&A meeting monthly for 3 months. | |
| F 309 SS=D | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING | F 309 | | 3/16/17 |

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| F 309 | Continued From page 5<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and resident, staff and Physician interview, the facility | F 309 | 1. Address how corrective action will be accomplished for those residents found to | |

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| F 309 | Continued From page 6<br>failed to review residents' weights per the Physician order which resulted in failure to evaluate the need for medical intervention for 1 of 5 residents reviewed. (Resident #98)<br><br>Findings included:<br>Record review revealed Resident #98 was admitted to the facility on 9/1/2015 with cumulative diagnoses which included Congestive Heart Failure (CHF) and Hypertension. The most recent Minimum Data Set (MDS) dated 12/20/2106 indicated Resident #98 was cognitively intact.<br><br>A review of the Care Plan dated 2/16/2017 listed a focus of risk for altered cardiac and respiratory status. Included in the interventions was to obtain weights as ordered and to notify the Physician of any abnormalities.<br><br>A review of Physician's orders revealed an order signed on October 25, 2016 for Resident #98 to be weighed 3 times a week on Monday, Wednesday and Friday and to notify the Physician if weight increased by 5 pounds.<br>A review of Resident #98's weights in the medical record revealed the following weights documented from October 25, 2016 to the last entered weight on February 2, 2017:<br>11/2/2016- 188.2 pounds<br>11/12/2016-191pounds<br>11/25/2016-193 pounds<br>12/2/2016-191 pounds<br>12/9/2016-195.6 pounds<br>1/5/2017-189.8 pounds<br>2/2/2017-188.5 pounds<br><br>An interview was conducted with Resident #98 on 2/15/2017 at 10:05AM. Resident #98 reported he | F 309 | have been affected by the deficient practice:<br>1a. Resident #98 was evaluated by facility Medical Director on 2/17/2017.<br>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:<br>2a. Current facility residents with a diagnosis of CHF have been weighed 3 times a week and MD notified of any weight gain as appropriate.<br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:<br>3a. Facility DON/designee to in-service direct care staff on all residents with a diagnosis of CHF to follow CHF protocol. Education will be provided at time of orientation for new employees.<br>3b. Orders have been reviewed by DON/designee for accuracy of CHF protocol.<br>3c. Facility DON/designee to in-service direct care staff that weights will be given to staff Charge Nurse/Unit Manager for monitoring of weight increase.<br>3d. Weights will be monitored by Charge Nurse/Unit Manager for accuracy and will notify MD of weight increases per CHF protocol and adjust orders as needed.<br>3e. Weights will be entered into PCC by staff CNA's and monitored by DON/designee.<br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>4a. Facility DON/designee will audit 4 | |

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| F 309 | Continued From page 7<br>was weighed by the Restorative Aide (RA) a few times a week. Resident #98 stated knowledge of the reason for the weights related to the diagnosis of CHF.<br><br>An interview was conducted with Nurse #3 on 2/15/2017 at 10:30AM. Nurse #3 reported familiarity with Resident #98's condition and care because she worked with Resident #98 daily. Nurse #3 stated Resident #98 was weighed daily but she was unaware of Resident 98's weight because the RA was responsible for the weights of residents. Nurse #3 reported the RA would weigh Resident #98 and report the weight to the nurse. Nurse #3 reported the RA had not reported Resident #98's weights for the last few weeks. Nurse #98 stated she had not asked the RA what Resident #98's weights were for the last few weeks because it was very busy working on the hall and she just didn't think about it. Nurse #3 reported Resident #98 was a CHF resident and monitoring weights was important but an assessment was made daily of his legs to see if there was any swelling.<br><br>An interview was conducted with the RA on 2/15/2017 at 1:30 PM. The RA indicated Resident #98 was weighed on Monday, Wednesday and Friday of each week. The RA reported the weights were obtained and reported to the staff nurse responsible for Resident #98. The RA stated the weights were entered in the computer by the nurse because the nurses were responsible for review of the weights. The RA stated Resident #98 was weighed after breakfast on 2/15/17 and the weight was reported to Nurse #3.<br><br>An interview was conducted with the Director of | F 309 | random charts that have a diagnosis of CHF for weight increases that exceed protocol and that MD is notified.<br>5. Results of the audits will be taken to QA&A meeting monthly for 3 months. | |

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| F 309 | Continued From page 8<br>Nursing (DON) on 2/16/2017 at 10:09AM. The DON reported the expectation was Resident #98's weights to be obtained as ordered and the weights reviewed by the staff nurse to evaluate the need for Physician intervention.<br><br>An interview was conducted with Resident #98's facility Physician on 2/17/2017 at 10:30 AM. The Physician reported the expectation was for weights to be obtained and reviewed by the facility nursing staff as ordered. The Physician reported clinical providers depended on the facility staff to evaluate the weights as ordered to ensure the residents receive the appropriate care and services. The Physician further stated the facility needed a system or protocol in place to ensure the weights were reviewed and evaluated as ordered for the need for Physician intervention. | F 309 | | |