| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345321 | A. BUILDING _____ B. WING _____ | 02/23/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KERR LAKE NURSING AND REHABILITATION CENTER | 1245 PARK AVENUE HENDERSON, NC 27536 |

| (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 000 | INITIAL COMMENTS<br><br>There were no deficiencies cited as a result of the complaint investigation survey of 2/23/17.<br>Event ID 1H5011 | F 000 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff and family interviews, and record review the facility failed to shave 1 of 3 residents reviewed for Activities of Daily Living care (Resident #120).<br><br>Findings included:<br><br>Resident #120 was admitted to the facility on 10/18/16. Active diagnoses included dysphagia, cognitive communication deficit, and muscle weakness.<br><br>Review of Resident #120's care plan dated 10/19/16 revealed the resident required assistance for personal hygiene. The interventions included to shave the resident.<br><br>Review of a resident concern dated 12/13/16 revealed Resident #120's family member expressed the family desired the resident to be shaved regularly. The intervention taken was the administrative nurse would monitor Resident #120's bath and shaving schedule.<br><br>Review of Resident #120's care guide dated | F 312 | Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceedings.<br><br>1. Corrective action for the resident | 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 312 | Continued From page 1<br>1/9/17 revealed the resident's Activities of Daily Living included to provide total care to resident which included shaving the resident.<br><br>Review of Resident #120's most recent Minimum Data Set assessment dated 1/18/17 revealed the resident was assessed as severely cognitively impaired. Resident #120 was totally dependent on staff for personal hygiene, which included shaving.<br><br>Review of Resident #120's shower schedule revealed the resident received baths on Mondays and Thursdays on 1st shift.<br><br>During observation on 2/20/17 at 1:19 PM, the resident was observed in bed with wife visiting. The resident had facial hair present.<br><br>During observation on 2/21/17 at 2:03 PM, the resident was observed in his recliner. The resident had facial hair present.<br><br>During an interview on 2/21/17 at 3:35 PM Resident #120's Responsible Party stated that the resident had preferred to be shaved every other day. She stated when Resident #120 first came to the facility she told the facility during admission that she wanted the resident to be shaved. She further stated that she had to shave the resident because the resident was not shaved by staff and would scratch his face after two or three days of facial hair growth. She stated the last time she shaved him was on 2/19/17.<br><br>During observation on 2/22/17 at 10:15 AM Nurse Aid #1 and Nurse Aid #2 were observed providing the resident his bed bath. The Nurse Aids did not offer or attempt to shave the resident. The | F 312 | affected:<br>Resident #120 was shaved 2/23/17 by Nurse Aide, supervised by Quality Improvement nurse.<br><br>2. Corrective action for residents having the potential to be affected:<br>100% audit of all residents to include Resident # 120, using a resident census, was completed on 2/27/17 by Director of Nursing, Quality Improvement Nurse, Patient Care Coordinator, Staff Facilitator to ensure ADL□s to include shaving had been completed appropriately. Any identified areas of concern were addressed immediately by Director of Nursing, Quality Improvement Nurse, Patient Care Coordinator, Staff Facilitator.<br><br>3. Measures put in place or systemic changes made to ensure this deficient practice does not reoccur:<br>100% of all Licensed Nurses and Nurse Aides, to include Nurse Aide #1, Nurse Aide #2 and Nurse #1, were educated by the Director of Nursing and Staff Facilitator on ADL□s to include shaving with return demonstration by 3/16/17. Newly hired staff will be inserviced on ADL care, to include return demonstration by Staff Facilitator during orientation<br>4. How the facility plans to monitor the measures to make sure solutions are sustainable.<br>Resident care audits, to include Resident # 120, will be conducted by Director of Nursing, Quality Improvement Nurse, Patient Care Coordinator, Staff Facilitator and Treatment Nurse to observe Nurse | |

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| F 312 | Continued From page 2<br>resident scratched at his face during the bath.<br><br>During observation on 2/22/17 at 3:59 PM Resident #120 was observed in bed. The resident had facial hair present.<br><br>During observation on 2/23/17 at 8:30 AM Resident #120 was observed in bed. The resident had facial hair present.<br><br>During an interview on 2/23/17 at 9:16 AM Nurse Aid #1 stated Resident #120 had not refused care. She stated that she used the shower sheet and care guide in the resident's closet door to guide her care. She further stated that she was aware that the resident's family wanted him to be shaved regularly and that it was on the care guide. She stated that she did not shave Resident #120 due to time constraints.<br><br>During an interview on 2/23/17 at 10:17 AM the Director of Nursing stated it was her expectation that the residents who wanted to be shaved would receive their shave at least on shower days. She further stated that when the resident moved to a different hall, the monitoring of the resident's shaving schedule must have been lost and Nurse #1 would have been the nurse to monitor for shaving but probably was not aware.<br><br>During an interview on 2/23/17 at 10:33 AM Nurse #1 stated she was aware on her rounds she was supposed to monitor facial hair of the residents. She further stated she was not aware that Resident #120 had not received a shave during the 4 days of the survey. She stated when she made her rounds nothing jumped out at her. | F 312 | Aides, including Nurse Aide #1 and Nurse Aide #2, providing ADL care to residents. Resident Care Audits will be completed on 10 % of Nurse Aides weekly to include nights and weekends x 8 weeks, then 10% of Nurse Aides monthly to include nights and weekends x 1 month using a Resident Care Audit Tool to ensure staff are providing appropriate ADL□s. The Nurse Aide will be immediately retrained during the audit for any identified areas of concern. The Resident Care Audit tools will be reviewed and initialed weekly by the Administrator or Director of Nursing to ensure compliance. The Administrator will compile the results of the Resident Care Audit tool and present to the Executive QI Committee monthly x 3 months. The identification of trends will determine the need for further action and/or change in frequency of required monitoring. | |
| F 322 | 483.25(g)(4)(5) NG TREATMENT/SERVICES - | F 322 | | 3/16/17 |

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| F 322 SS=D | Continued From page 3<br>RESTORE EATING SKILLS<br><br>(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review the facility failed to check gastrostomy tube placement before the administration of a flush for 1 of 1 residents reviewed for gastrostomy tube care (Resident #120).<br><br>Findings included:<br><br>Review of the facility's policies and procedures regarding medication administration through a gastrostomy tube, revised 12/3/12, revealed that for unstabilized gastrostomy tubes the gastrostomy tube should be tested for placement | F 322 | Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance.<br>Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor | |

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| F 322 | Continued From page 4<br>by aspiration (removal by suctioning of fluids) of stomach contents.<br><br>Resident #120 was admitted to the facility on 10/18/16. Active diagnoses included dysphagia and the presence of a gastrostomy tube.<br><br>Review of the resident's most recent Minimum Data Set assessment dated 1/18/17 revealed the resident had a feeding tube and was assessed as severely cognitively impaired.<br><br>During observation on 2/22/17 at 9:30 AM Nurse #2 flushed Resident #120's unstabilized gastrostomy tube with 100 milliliters of water. The nurse did not aspirate the gastrostomy tube to check the placement before flushing the tube.<br><br>During observation on 2/22/17 at 1:40 PM Nurse #2 flushed Resident #120's gastrostomy tube with 100 milliliters of water, and again the nurse did not aspirate the gastrostomy tube to check the placement before flushing the tube.<br><br>During an interview on 2/22/17 at 1:44 PM Nurse #2 stated that she was supposed to check for gastrostomy tube placement every time she flushed it. She stated that she did not check for placement and she should have.<br><br>During an interview on 2/22/17 at 2:05 PM the Director of Nursing stated the policy and procedure for administration of oral medication through a gastrostomy tube should be followed when residents received a gastrostomy tube flush. She stated her expectation was that nurses checked residents' gastrostomy tubes for placement before they administered flushes for residents with unstabilized gastrostomy tubes. | F 322 | does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceedings<br><br>1. Corrective action for the resident affected:<br>Resident #120 gastrostomy tube placement was checked prior to flushing on 2/22/17 by Patient Care Coordinator with supervision by the Director of Nursing.<br><br>2. Corrective action for residents having the potential to be affected:<br>100% of License Nurses to include Nurse #2, were observed administering medications via gastrostomy tube to ensure gastrostomy tube placement was checked per policy prior to the administration of a flush on 2/22/17 by the Director of Nursing. The Director of Nursing immediately retrained the license nurse for any identified areas of concern during the audit.<br><br>3. Measures put in place or systemic changes made to ensure this deficient practice does not reoccur:<br>100% of License Nurses to include Nurse #2 will be inserviced by the Director of Nursing or Staff Facilitator regarding the policy and procedure for checking gastrostomy tube placement prior to the | |

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| F 322 | Continued From page 5<br>She further stated that Resident #120 had an unstabilized gastrostomy tube and that Nurse #2 should have checked the gastrostomy tube for placement. | F 322 | administration of a flush by 3/16/17. All newly hired license nurses will be inserviced regarding the policy and procedure for checking gastrostomy tube placement prior to the administration of a flush during orientation by the Staff Facilitator.<br><br>4. How the facility plans to monitor the measures to make sure solutions are sustainable:<br>The Medication Pass Audit Tool will be utilized by the Director of Nursing, Quality Improvement Nurse, Patient Care Coordinator, Staff Facilitator and Treatment Nurse with observation of 10% of license nurses to include nurse #2 to ensure license nurses are checking gastrostomy tube placement per policy prior to the administration of a flush weekly x eight weeks then monthly x 1 month. Immediate retraining will be conducted with the licensed nurse for any identified issues observed during the medication pass audits by the Director of Nursing, Quality Improvement Nurse, Patient Care Coordinator, Staff Facilitator and Treatment Nurse. The Director of Nursing or Administrator will review and initial the Medication Pass Audit Tool for appropriate flushes to residents to include resident #120, for completion, and to ensure all areas of concern were addressed weekly x eight weeks then monthly x 1 month. The Executive QI committee will meet monthly and review QI Medication Pass Audit Tool and address any issues, concerns and\or trends and to make changes as needed, | |

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| F 322 | Continued From page 6 | F 322 | to include continued frequency of monitoring x 3 months. | |