STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(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 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to follow an intervention on the care plan and Kardex, for one of one resident (Resident #1) who was to receive nothing by mouth. The findings included: Resident #1 was originally admitted to the facility on 4/27/17, discharged to the hospital on 5/22/17, and then readmitted to the facility on 5/25/17. Resident #1 had the following diagnoses: Gastrostomy (feeding tube), Dysphagia (swallowing disorder/impairment), Hemiplegia (left sided weakness) following a stroke, and cognitive impairment. Review of Resident #1's most recent comprehensive Minimum Data Set (MDS) assessment, an admission assessment dated 5/4/17, revealed Resident #1 required maximum assistance of two or more people for bed mobility, was totally dependent on one person for eating, and was totally dependent on two or more people for transferring. According to the 5/4/16 MDS assessment Resident #1 had severely impaired cognition and was coded as receiving nutrition and hydration via a feeding tube.	F 282	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F282 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #1 care plan was accurate with NPO care plan in place. F282 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: The Director of Nursing (DON)/Unit Manager or designee reviewed/updated all NPO care plans for	6/16/17

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

Electronically Signed | 06/15/2017

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F 282	Continued From page 1 Review of Resident #1's Care Plan with a last review date of 5/18/17 revealed a focus area that read, the resident has an Activities of Daily Living (ADL) self-care performance deficit related to Activity Intolerance, Disease Process, Stroke, and Hemiplegia. The goal listed was for the resident to improve current level of function through the review date. The intervention listed for eating was that the resident was nothing by mouth (NPO) and was on tube feedings. This focus area, goal, and intervention had a created date and a revision on date of 4/28/17. Review of Resident #1's physician's orders revealed an order dated 5/25/17, at the time of readmission, to not receive any food or drink orally. An interview that was conducted with Nurse #1 on 5/31/17 at 11:23 AM revealed she was Resident #1's assigned nurse. Nurse #1 provided the information that Resident #1 had a feeding tube for continuous feeding, was nothing by mouth, and due cognitive loss, the resident was not interviewable. In addition, Nurse #1 stated Resident #1 was completely paralyzed on her left side and required maximum assistance for Activities of Daily Living, such as transfers, and mobility. An interview that was conducted with Nursing Assistant (NA) #1 on 5/31/17 at 11:34 AM revealed she had been assigned to Resident #1 for day shift that day. NA #1 stated that normally Resident #1 was not on her assignment but was that day. NA #1 was aware that Resident #1 received her hydration and nutrition through the feeding tube and that she did not receive meal	F 282	current interventions on 6/5/17. Nurses and certified nursing assistants (CNAs) received education on following the care plan interventions related to NPO (began 6/9/17 and completed 6/15/17) by Staff Development Coordinator (SDC). No current nurses or CNAs on leave or FMLA and all staff received training prior to returning to work. F282 Measures to be put in place or systemic changes made to ensure practice will not re-occur: New nurses and CNAs will receive education on following the care plan interventions related to NPO status during orientation. The DON/Unit Manager or designee, will interview 5 CNAs weekly on care planned kardex interventions, then twice a month x 2 months (began 6/9/17 and will complete August 2017). Any deficient practice will result in re-education and/or disciplinary action as needed. F282 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting x 3 months and Quarterly Quality Assurance meeting X 1 for further resolution if needed. Date of compliance: June 16, 2017	

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trays.

An observation of Resident #1 on 5/31/17 at 11:53 AM revealed Resident #1 to be sitting in her room, in her wheelchair at the bedside with the over the bed tray table positioned in front of her. There was a feeding tube present, with a pump, and container of formula hanging on an intravenous (IV) pole. The pump was observed to be on and running. Resident #1 had a black coffee mug sitting on the table in front of her within her reach that was approximately half full of a liquid that appeared to be coffee. The resident had her call light in her hand and pressed the call light button at 11:53 AM. There were no staff members in the room and when the resident was asked if she needed something, the resident responded, "no." The call light was answered by NA #1 and NA #2 at 11:55 AM. The resident was asked by the NAs if she needed anything. The resident responded she wanted something for her dry mouth. The NAs left the room. The resident picked up the coffee cup and took a drink. When the two NAs returned to the room at 11:57 AM with mouth swabs for the resident, the NAs were questioned if Resident #1 was NPO. The NAs responded that neither of them were aware the resident was nothing by mouth. The NAs were made aware that the resident had a coffee cup and had been observed drinking from it. NA #1 stayed in the room with the resident. NA #2 went out of the room to obtain information regarding the resident's dietary status. NA #2 returned to the resident's room at 12:01 PM and revealed that the resident had an order dated 5/25/17 that the resident was NPO. Neither of the NAs were able to provide an explanation as to how the resident had received the coffee cup. The coffee cup was removed

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from the room by the NAs.

In an interview conducted with NA #1 on 6/1/17 at 8:55 AM NA #1 revealed she was able to identify if a resident was NPO by checking the care guide and the resident's nurse would also verbally communicate that a resident was nothing by mouth. NA #1 expressed she was aware if a resident had a feeding tube the resident may be nothing by mouth. NA#1 stated the care guides had been printed out for the NAs. The facility was in transition though and was going to a paperless system. NA #1 was unable to locate a paper care guide for Resident #1. NA #1 was not aware how Resident #1 had received the coffee cup. NA #1 stated most of the facility staff were aware that Resident #1 was NPO and that this had been the first time she had seen Resident #1 with something to drink. NA #1 further clarified that she had not seen the coffee cup when had first entered the room to answer the call light on 5/31/17. When she returned to the room with NA #2 she became aware that the resident had the coffee cup and then the coffee cup was removed.

In an interview that was conducted with NA #3 on 6/1/17 at 9:32 AM revealed NA #3 stated the facility used to have care guides for the residents on a paper copy, but now everything was online. NA #3 logged into her account on a wall mounted monitor and was able to show resident information that was available to the NAs in the Electronic Medical Record (EMR) system. NA#3 stated if she needed information she would be able to log into the EMR and obtain the information from the Kardex. She stated the Kardex was an online document that provided resident care information and was available for the NAs to review.

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In an interview conducted with NA #1 on 6/1/17 at 10:54 AM NA #1 stated that resident nutrition information was available through the EMR on the Kardex. NA #1 demonstrated how to access Resident #1's Kardex. A review of Resident #1's Kardex revealed that Resident #1 had information under the intervention for Eating/Nutrition that detailed Resident #1 was NPO and was on a feeding tube. NA #1 acknowledged that the Resident #1's Kardex provided information that Resident #1 was nothing by mouth.

An interview conducted with the Director of Nursing (DON) on 6/1/17 at 11:56 AM revealed her expectation would be for an NA to review the Kardex to familiarize themselves with the residents who were on their assignment. If the NA had a question about the care to be provided, the NA could refer back to the Kardex or consult the nurse. The DON further clarified that by addressing a resident's nothing by mouth status under the ADL focus area it will trigger for the nothing by mouth status to be carried over to the Kardex. The DON reviewed Resident 1's care plan and confirmed that it was care planned that the resident was NPO. The DON reviewed Resident #1's Kardex and confirmed that the resident's status of nothing by mouth was under Recommendations-Strategies. The DON stated the information regarding Resident #1 being nothing by mouth was available to the NAs. The DON further added that an active investigation was ongoing in an effort to determine how Resident #1 had received the cup of coffee.

An interview that was conducted with the Administrator on 6/1/17 at 12:53 PM revealed his expectation was for an NA to review the Kardex

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F 282	Continued From page 5 to familiarize themselves with the residents who were on their assignment. If the NA had a question about the type of care needed the NA could refer back to the Kardex or consult the nurse.	F 282		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide supervision to prevent a resident from consuming liquids for one	F 323	F323 How corrective action will be accomplished for each resident found to have been affected by the deficient	6/16/17

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F 323	Continued From page 6 of one resident (Resident #1) who was to receive no food or drink by mouth. The findings included: Resident #1 was originally admitted to the facility on 4/27/17, discharged to the hospital on 5/22/17, and then readmitted to the facility on 5/25/17. Resident #1 had the following diagnoses: Gastrostomy (feeding tube), Dysphagia (swallowing disorder/impairment), Hemiplegia (left sided weakness) following a stroke, and cognitive impairment. Review of Resident #1's most recent comprehensive Minimum Data Set (MDS) assessment, an admission assessment dated 5/4/17, revealed Resident #1 required maximum assistance of two or more people for bed mobility, was totally dependent on one person for eating, and was totally dependent on two or more people for transferring. According to the 5/4/16 MDS assessment Resident #1 had severely impaired cognition and was coded as receiving nutrition and hydration via a feeding tube. Review of Resident #1's Care Plan with a last review date of 5/18/17 revealed a focus area that read, the resident has an ADL self-care performance deficit r/t related to Activity Intolerance, Disease Process, Stroke, and Hemiplegia. The goal listed was for the resident to improve current level of function through the review date. The intervention listed for eating was that the resident was nothing by mouth (NPO) and on tube feedings. This focus area, goal, and intervention had a created on date and a revision on date of 4/28/17. Review of Resident #1's physician's orders	F 323	practice: Resident #1 had coffee removed from room at time of discovery, MD was notified of incident and no adverse outcome from non-compliance noted. F323 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: The Director of Nursing (DON)/Unit Manager or designee audited all NPO patients to ensure care planned interventions are in place (completed 06/05/17). Any interventions not in place will involve staff re-education, and if practice continues, the staff will receive disciplinary action. All certified nursing assistants (CNAs) received education on NPO status and where to locate on the Kardex (began 6/9/17 and completed 6/14/17) by Staff Development Coordinator (SDC). Ongoing education for orientation and as needed by SDC/DON or designee. No current nurses or CNAs on leave or FMLA and all staff received training prior to returning to work. F323 Measures to be put in place or systemic changes made to ensure practice will not re-occur: New nursing staff will continue to receive education on NPO status and how to access kardex during orientation (ongoing education for orientation and as needed by SDC/ DON or designee). Audits will be done on all NPO residents to assure there are no liquids at bedside weekly x 4 week, then monthly x 2 (began 6/5/17 thru August 2017) by DON/UM or designee.	

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F 323	Continued From page 7 revealed an order dated 5/25/17, at the time of readmission, to not receive any food or drink orally. Review of Resident #1's Speech Language Pathology Evaluation and Plan of Treatment dated 5/26/17 revealed Resident #1 was identified as at risk for aspiration. The evaluation indicated Resident #1 had severe clinical signs and symptoms of dysphagia with thin liquids. It was documented that the resident had no awareness of food or drink in her mouth or the need to swallow. The risk factors identified during the evaluation included: physical impairments, associated functional deficits, at risk for aspiration, further decline in function, and increased dependency on caregivers. The recommendations from the evaluation included that the resident not eat or drink anything by mouth. An interview that was conducted with Nurse #1 on 5/31/17 at 11:23 AM revealed she was Resident #1's assigned nurse. Nurse #1 provided the information that Resident #1 had a feeding tube for continuous feeding, was nothing by mouth (NPO), and due cognitive loss, the resident was not interviewable. In addition, Nurse #1 stated Resident #1 was completely paralyzed on her left side and required maximum assistance for Activities of Daily Living, such as transfers, and mobility. An interview that was conducted with Nursing Assistant (NA) #1 on 5/31/17 at 11:34 AM revealed she had been assigned to Resident #1 for day shift that day. NA #1 stated that normally Resident #1 was not on her assignment but was that day. NA #1 provided further information that	F 323	F323 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting x 3 months and Quarterly Quality Assurance meeting X 1 for further resolution if needed. Date of compliance: June, 16, 2017	

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Resident #1 had attended Speech Therapy (ST) that morning and then had Occupational Therapy (OT) after that. NA #1 was aware that Resident #1 received her hydration and nutrition through the feeding tube and that she did not receive meal trays. NA #1 also stated Resident #1 had returned from therapy and was sitting in her room.

An observation of Resident #1 on 5/31/17 at 11:53 AM revealed Resident #1 to be sitting in her room, in her wheelchair at the bedside with the over the bed tray table positioned in front of her. There was a feeding tube present, with a pump, and container of formula hanging on an intravenous (IV) pole. The pump was observed to be on and running. Resident #1 had a black coffee mug sitting on the table in front of her within her reach that was approximately half full of a liquid that appeared to be coffee. The resident had her call light in her hand and pressed the call light button at 11:53 AM. There were no staff members in the room and when the resident was asked if she needed something, the resident responded, "no." The call light was answered by NA #1 and NA #2 at 11:55 AM. The resident was asked by the NAs if she needed anything. The resident responded she wanted something for her dry mouth. The NAs left the room. The resident picked up the coffee cup and took a drink. When the two NAs returned to the room at 11:57 AM with mouth swabs for the resident, the NAs were questioned if Resident #1 was nothing by mouth. The NAs responded that neither of them were aware the resident was NPO. The NAs were made aware that the resident had a coffee cup and had been observed drinking from it. NA #1 stayed in the room with the resident. NA #2 went out of the room to

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obtain information regarding the resident's dietary status. NA #2 returned to the resident's room at 12:01 PM and revealed that the resident had an order dated 5/25/17 that the resident was NPO. Neither of the NAs were able to provide an explanation as to how the resident had received the coffee cup. The coffee cup was removed from the room by the NAs.

Another interview was conducted with Nurse #1, on 5/31/17 at 12:03 PM. Nurse #1 confirmed that Resident #1 was NPO. Nurse #1 further explained that she had been informed that Resident #1 had a coffee cup and was observed drinking from it. Nurse #1 stated she did not know how Resident #1 had obtained the coffee cup.

An interview that was conducted with the Speech Therapist (ST), on 5/31/17 at 1:49 PM, revealed that she had been working Resident #1 earlier in the morning. Through conversation with the ST it was discovered that she had not given Resident #1 the coffee cup. The ST further clarified because of the resident's nothing by mouth status and high risk for aspiration that when she worked with the resident she had only given her two pieces of ice chips as a therapeutic trial. The ST stated Resident #1 did well with the pieces of two pieces of ice chips but did not feel that the resident was safe at that point to have a more liberalized diet, including more liquids or solid foods.

In an interview with Nurse #1 on 5/31/17 at 1:59 PM, she stated Resident #1 told her [Person #1] had given her the coffee cup. Nurse #1 clarified there was no staff member or resident named [Person #1] nor was facility staff aware of a visitor

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or family member named [Person #1]. Nurse #1 added that it had been discovered Resident #1 had asked for drinks from other residents.
An interview that was conducted with the 100 Hall Unit Manager, on 5/31/17 at 2:30 PM, revealed NA #2 was a scheduler and did not usually carry a patient load and was not familiar with the residents or if a resident was NPO. The Unit Manager stated NA #1 had regularly worked with Resident #1 and should have observed Resident #1 had a coffee cup in her room and should have removed it when she had seen it. The Unit Manager was unable to provide an explanation as to how Resident #1 had received the coffee cup. The Unit Manager stated there was a coffee urn behind the nurses' station with coffee cups that matched the coffee cup that was found in Resident #1's room. The Unit Manager added she was going to write up an in-service for the nursing staff regarding NPO residents. The Unit Manager also stated the facility staff believed the cup of coffee had been given to Resident #1 by a visitor, but it had not been verified.

An interview conducted with NA #1, on 6/1/17 at 8:55 AM revealed she was able to identify if a resident was NPO and the resident's nurse would communicate that a resident was nothing by mouth. NA #1 expressed she was aware if a resident had a feeding tube the resident may be NPO. NA #1 stated the care guides had been printed out for the NAs. The facility was in transition though and was going to a paperless system. NA #1 was unable to locate a care guide for Resident #1. NA #1 was not aware how Resident #1 had received the coffee cup. NA #1 stated most of the facility staff were aware that Resident #1 was NPO and this had been the first time she had seen Resident #1 with something to

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drink. NA #1 further clarified she had not seen the coffee cup when she had first entered the room to answer the call light on 5/31/17. When she returned to the room with NA #2 she became aware that the resident had the coffee cup and then the coffee cup was removed.

In an interview conducted with NA #1 on 6/1/17 at 10:54 AM she stated resident nutrition information was available through the Electronic Medical Record (EMR) on the Kardex. NA #1 demonstrated how she was able to access Resident #1's Kardex. A review of Resident #1's Kardex revealed Resident #1 had information under the intervention for Eating/Nutrition that detailed Resident #1 was NPO and was on a feeding tube. NA #1 acknowledged that the Resident #1's Kardex provided information that Resident #1 was nothing by mouth.

An interview conducted with the Director of Nursing (DON) on 6/1/17 at 11:56 AM revealed her expectation would be for a NA to be knowledgeable about the resident's on an assignment. As well as being knowledgeable nursing staff should be aware NPO residents should not receive food or liquids. If the NA had a question about if a resident should receive food or liquids, the NA could refer back to the Kardex or consult the nurse. The DON further added that an active investigation was ongoing in an effort to determine how Resident #1 had received the cup of coffee.