DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011
FORM APPROVED STATES

		WIEDICAID SERVICES			O	<u> MR MC</u>	<u>). 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI	-		DATE SUI COMPLET	
		345124	B. WI	IG			C 9/2011
NAME OF P	ROVIDER OR SUPPLIER					09/0	8/2011
				1	EET ADDRESS, CITY, STATE, ZIP CODE 60 JOHNSON RIDGE RD		
HERITAG	E HEALTHCARE OF ELK	in in		ŀ	LKIN, NC 28621		
(X4) ID	SHIMMADV STA	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
F 221 SS=E	483.13(a) RIGHT TO PHYSICAL RESTRAI	NTS	F	221	Disclaimer Clause: Preparation an execution of	nd/or	
	physical restraints imp	nce, and not required to			This POC does not constitute admission or agreement by		
	by:	is not met as evidenced			The provider of the truth of the fa alleged or	acts	
	Based on observation	s, staff and family			Conclusion set forth in the statem	nent	
	interviews and record	reviews, the facility failed to		ĺ	of deficiencies the POC is		
	residents with restraint	oms for 3 of 4 sampled is and failed to implement			of deficiencies the POC is	-	
	systematic approaches	s to reduce					
i	restraints(Residents #				Prepared on/or executed solely		
		10 1, 11 100 and 1104).	1		because it is required by Federal a	and	
	The findings included:						
	-Facility policy titled " F	Physical Restraint " dated	ļ		State Law.		
	9/10, read in part; all re require a physical restrorder for the device. The be included in the physical graphs of the physical restraint is used and the monitored according to the addition, restraint commonthly or more frequently or more fr	esidents determined to raint will have a physician's me following information will sician's order; medical type of restraint, why the e physical restraint is to be the individuals care plan. It is mitted will meet at least ently as determined by center need. The following resical restraint e that all possible physical ave been attempted for a late each resident for least resical restraint in place, is order for			·		
	appropriateness, review	each care plan and ADL					
BORATORY D	RECTOR'S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURE			TITLE	/~/	B) DATE

10-0le-11

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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FORM APPROVED TO NO. 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SU COMPLET	TED
		345124	B. Wil	IG		ļ	C 09/2011
NAME OF P	ROVIDER OR SUPPLIER		·	STE	REET ADDRESS, CITY, STATE, ZIP CODE	0010	13/2011
HEDITAG	C UEAL TUCABE OF ELV	181		1	660 JOHNSON RIDGE RD		
HEIMIAG	E HEALTHCARE OF ELK	IIN		E	ELKIN, NC 28621		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON	0.51
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR I	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 221	the resident's assessed regarding physical resident's family/respondified. When the resident was been determined intervention for emergiand treatment, the physical for certain time proditions, referring retherapy, activity, social indicated in effort to reevaluating the physical adaptations that would physical restraint usage the resident's MDS, see be coded for those develophysical restraint and renables the resident to	hether they are reflective of and needs and interventions traints, determine that the possible party has been ident's physical restraint to be used as an ent and/or therapeutic care resical restraint will only be eriods and under specific sident's for behavioral, I or other programs as duce physical restraints, I environment for potential eliminate or decrease e. Reporting and coding on action P40100 should only	F	221	1. Corrective action has be accomplished for the a deficient practice for Ref # 134,100, and 84 thro reevaluation and reassessment of the new for physical devices. Be the reevaluations, the uphysical devices was determined based on individual resident need such determinations recappropriately in the clinic record. 2. Residents with the pote	esidents bugh ecessity ased on use of ds and corded ical	,
	11/5/09. Resident #134 included dementia, cer congestive heart failure weakness and degene quarterly Minimum Dat 8/17/11, indicated that short and long term me problems. The MDS als #134 was hard of heari an assistive device and understanding verbal chelp make sense of the tone was not at an elev Section P of the MDS vof restraint. Resident #	a cumulative diagnoses ebral vascular accident, e, general muscle rative joint disease. The a Set (MDS) dated Resident #134 had severe emory and decision making so indicated that Resident ing and required the use of a still had difficulty content and reminders to a things even when voice ated volume in one ear. avas not coded for the use and made some progress,		**************************************	be affected by the allege deficient practice were identified through 100% of residents with an asseneed for safety devices, residents with safety devices place were reassessed the least restrictive device, implemented.	audit essed All vices in with	9-22-11

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	KS FOR MEDICARE &	MEDICAID SERVICES		•		 OMB NO 	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION 1 19/2 (3/12/10) TO THE ACT OF THE ACT O	(X3) DATE SUI COMPLET	RVEY VIII 17
		345124	B. WING				C 9/2011
NAME OF P	ROVIDER OR SUPPLIER			OTOE	TARRESON OUTVIEW THE THE CORE	0070	0/2011
	E HEALTHCARE OF ELK	SIN .	ľ	560	ET ADDRESS, CITY, STATE, ZIP CODE JOHNSON RIDGE RD KIN, NC 28621		
/V4) ID	SHIMMADV ST	ATEMENT OF DEFICIENCIES			· · · · · · · · · · · · · · · · · · ·		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 221	Continued From page ambulation. The physician's order lap buddy for safety a	dated 8/7/11, documented	F 22	- [!] 3	 Measures put in place ensure the alleged defi practice does not recur include: The Clinical Ca 	cient	10-19-11
	no medical symptom in has been in restorative per day since January physician's notes date revealed that Residen hearing, general health notation of concerns we mobility. The notes independs most of her tindown and continues to and overall health was revealed the alth was revealed that upon staff for locomoti off the unit. Resident # assist from the staff ar use of rolling walker. For can't roll that far yet, with staff with use of a decreased standing an assistance from staff. The physical restraint of the medical symptom we consideration of the phapplicable). Resident # assistance with bed mo occasional incontinent Follow-up assessment revealed the medical symptom we revealed the medical symptom we consideration of the phapplicable). Resident # assistance with bed mo occasional incontinent Follow-up assessment revealed the medical symptom we revealed the medical symptom we consideration of the phapplicable). Resident # assistance with bed mo occasional incontinent Follow-up assessment revealed the medical symptom we considerated the medical symptom we called the medi	d 5/23/11 to 8/9/11, t #134 's was very hard of h remains stable and no with falls, transfers or dicated that Resident#134 he sitting with her legs be monitored for edema stable. daily living Resident (RAP) summary dated Resident #134 depended on once in the wheelchair that ambulated with limited had restorative aides with Resident #134 stated "I just Resident was ambulating rolling walker. She had had sitting balance requiring evaluation dated 8/7/11, levice was a lap buddy and which led to the hysical device was N/A(not that required extensive biblity and transfers, of bowel and bladder.		4	Coordinator will inservice nursing staff on use of staff on the results of staff on use of staff on the results of monitoring to ensure compliance.	ce all safety f Health sistant ces will he a week then pliance nted to cies or use. Ing will morning uring PI will be sary	10-13-16

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NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE				
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		WIV.		ELK	IN, NC 28621				
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F 221	with restorative. Addited 9/9/11, reveale use lap buddy and the included, muscle weat without 1 to 2 assist, balance. There was not therapy assessment and 8/16/11. On 6/18. Resident#134 was obthe bedroom in front of #134 stated that "I was was the only incident observed on the floor did not indicate wheth the wheelchair or bed incidents of falls until included "making sure attached to resident whad been implemente Resident had not had 8/16/11 staff was presto stand up and fell to lap buddy. There were no incidents, nor was the	tional follow-up assessment d that Resident continue to e medical symptom kness and unable to stand improve posture and to current rehabilitation available. Review of the ident reports dated 6/18/11 //11, revealed that served sitting on the floor in of wheelchair and Resident as trying to get up. " This where the resident was in the bedroom. The report ter the resident had fell from . There were no further 8/16/11. The intervention	F	221	. Midble.	1 Security			
	the problem as: 1. pote 6/18/11 and 8/16/11 w buddy and stood up w unsteady, balance is in Resident #134 will havinjuries x 90 days. The	an dated 8/22/11, identified ential for falls r/t falls on when she took off her lap ithout assistance gait enpaired. The goal was be no falls r/t(related to) approaches included for assist with transfers							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION CONTROL OF THE CONTRO	COMPLET	RVEY REPARENT ED INTEREST
		345124	B. WIN	G		ĺ	9/2011
	OVIDER OR SUPPLIER	IN	•	5	EET ADDRESS, CITY, STATE, ZIP CODE 60 JOHNSON RIDGE RD ILKIN, NC 28621		
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F 221	transfers, remind resist transfers and to use he lap buddy. 2. Decline independently. The gowill ambulate 50-125 approach included the supervision and verbaclose to rolling walker program. There was replan of the frequency lap buddy. During an observation Resident #134 was seroom with lap buddy in able to reposition self put her to bed. Resident know what the pill to remove the lap buddher to bed. NA# 3 indivase used to prevent for remove the lap buddy. During an observation Resident #134 was seen the lap buddy was using the arm resident #134 was seen the resident #134 was seen t	reach, maintain safety with dent to call for assist with her walker with ambulation, in ability to ambulate pal included Resident #134 fit daily x 90 days. The experience rolling walker with all cues to stand up tall stay, monitor and document no indication on the care and duration of use for the experience. Resident #134 was in chair and asking staff to ent #134 stated that she did ow was for. She was unable dy when NA #3 was putting cated that the lap buddy alls and resident could not NA #3 indicated that she dent stand up unassisted or	L.	221		const const	
	nor to you.						İ

		ND HUMAN SERVICES:			T. S. M. C. J. C. S. M. C. S.		M APPRÓVEÓ O. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY BOAS COMPLETED		G 135. 4
		345124	B. WIN	1G			C 19/ 2011	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E HEALTHCARE OF ELK	IN			560 JOHNSON RIDGE RD ELKIN, NC 28621			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	- 3-
F 221	Continued From page	5	F	221				
	in place at nurse's sta repetitive movements	eated in hall with lap buddy tion. There was no leaning, or difficulty with air. The lap buddy was				مين الد 11 ترون	on somethings and a second	
:		eated in door way with lap betitive movements. The lap						
	DON(director of nursir responsible for the fall She added that the co discussion regarding t for Resident #134 bas and 8/16/11. She furth knew the resident sea therefore she applied stated that Resident # to the physical therapy	he least restrictive device ed on the falls on 6/18/11 her stated that because she t belt would not work, the lap buddy. She also 134 had not been referred t department and the lap l for positioning, resident						
e e e e e e e e e e e e e e e e e e e	forward. In addition, Reassessed for any other interventions and there assessment process in	esident #134 had not been ralternative devices or						~~ · · · ·
		9/8/11 at 10:58AM, NA #5 ve ambulation consist of 0 ft depending on the						

resident program. Resident #134 was waked daily with rolling walker for 15 minutes. Resident

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independently.

reposition self in a chair independently and did not have any positioning concerns. In addition, Resident #134 would verbally let you know when she wanted to go to bed and the resident had the lap buddy a few months. NA #6 added that Resident #134 was unable to remove the lap buddy on command. NA #6 did not indicate that she had seen the Resident #134 get up

During an interview on 9/8/11 at 11:55AM, NA#2

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Facility ID: 923208

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PRINTED: 09/27/2011 DEPARTMENT-OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	DING	CONSTRUCTION CHARACTER TO THE	COMPLET	RVETO TATALA ED TATALA (DE	TO AND STOR
		345124	B. WIN	G			C 9/2011	ate to e
	ROVIDER OR SUPPLIER E HEALTHCARE OF EL	KIN	· · · · · · · · · · · · · · · · · · ·	560.	T ADDRESS, CITY, STATE, ZIP CODE JOHNSON RIDGE RD IN, NC 28621			
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F 221	one person assistan living. The NA's add provided with staff a bathroom with rolling to ambulate with littl walker. Resident #1 in a chair as long as 's indicated that the #134 falling from a cleaning other than woff in the chair. Both Resident #134 had months and it was un Resident #134 not to safety. Resident was buddy on command	I that Resident #134 needed a lice with activities of daily ed that encouragement was ssistance to walk to the g walker. Resident was able e difficulty when holding onto 34 was able to reposition self the chair had arms. Both NA y were unaware of Resident thair or had an issue with then she was tired or dosing NA's indicated that the lap buddy at least 6 sed as a reminder for get up unassisted and for s unable to remove the lap. Both nursing assistants' unaware of seeing the	F	221				TO BE SECTION
1	ADON, indicated the and positioning after indicated that DON! She was uncertain or restraint process an added after review one incident of which resident removed the added that she had the lap buddy on conducting a family interfamily member indicated the use of the restrated director of nursir	on 9/8/11 at 12:15PM, the at the lap buddy was for safety reviewing the MD order. She handled the restraint process. of the determination or the d the documentation. She of the nurse! s note that only hit was documented that the e lap buddy. She further not seen the resident remove mmand or otherwise. View on 9/8/11 at 1:30PM, ated that they had requested int(seat belt), but was told by ag that the seat belt would not ap buddy was put in place. In			1 ;	J 2.		

STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION.		TED	
		345124	B. WING		09/09/2011		
NAME OF PE	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E HEALTHCARE OF E	LKIN		560 JOHNSON RIDGE RD ELKIN, NC 28621			
(X4) ID	SHMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
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F 221	Continued From pa	αe 8	F 22	21			
	•	member stated that Resident		-			
		when she was tired and the				1	
		g used for positioning, safety					
		sident #134 to place items.					
		The second	or the same				
		on 9/8/11 at 5:07PM, NA #4					
		ip buddy was in place cause					
		prevent the resident from ad that two weeks ago the					
		e the lap buddy in place					
		nber want her to have it and					
		It that the resident had slid out					
		ey wanted the resident to have					
	it back. NA#4 adde	d that Resident #134 was able					
		chair and generally falls	ļ.,				
	•	that is when she leans. In	·				
		#134 was unable to remove					
		was unaware of the resident					
	getting up without a	ssistance.					
	During a follow-up i	nterview on 9/9/11 at 3:23PM,					
		that the medical reason for		İ			
	•	uddy was because Resident					
		s, unable to stand without					
		ing and to improve posture					
		dded after review of the					
		nd fall type, that maybe the straint and should have been	# : TIT 154		rander to green pour porce		
	• •	on the MDS. She further stated					
		#134 was observed once to					
a. da. a.		dy that was the reason why it					
	_	also added that the resident					
	could not remove it	on command.					
	2. Resident #100 wa	as admitted to the facility on					
		le diagnoses including					
	hypertension, hypot	hyroidism, organic brain		***			
		, depression, anxiety and				1	

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JI TIPI E O	ONSTRUCTION FOR TAXABLE CONTRACTOR OF THE VIOLENCE	(X3) DATE SU	O. 0938-0391 JRVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	[6.2,	٠.		COMPLE		
							С	
-		345124	B. WIN	٠ <u>. </u>		09/0	09/2011]
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E HEALTHCARE OF ELH	KIN			PHNSON RIDGE RD	-		
	CHRIMADYOT	ATCHENT OF PERSONS		ELKIN	I, NC 28621		1	_
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F 221	Continued From page	e 9	F3	221				
		nificant change in status	' -	'				
	assessment dated 6/2	29/11 indicated that the						
		and decision-making						
		d extensive assistance with ssistance with						1.
		as no mention of restraint.	\$ 5,00 + 1	1				İ
	The quarterly MDS (N							
		22/11 indicated that the						
	resident had no restra							
	revealed the resident	ties of daily living, transfers,						
	mobility, ambulatory,							
		one-person assistance.						
	" D/c [discontinue] sea	dated 1/6/11 documented: atbelt to wheel chair. 2. May [lap buddy] in wheelchair ues. "						
	9/6/11 documented: ' up to the desk wheeld lying supine in front of	dent's incident report dated ' pt [patient] was pulling self chair, flipped forward, pt f desk, lap buddy intact. beside pt. Pt leg rolled to r injury. "						
**	Review of the resident was restraint.	t.care.plan dated 8/3/11,, vas not care-planned for a			: 1	·-··		
	Resident #100 was of	oserved on 9/6/11 at 3:00						
	p.m. The resident was	in her room. A lap buddy sident's wheelchair. The		***************************************				
	On 9/7/11 at 8:40 a.m observed in her wheel eating breakfast with t	chair in the dining room						

PRINTED: 09/27/2011 DEPARTMENT OF HEALTH AND HUMAN/SERVICES DEPARTMENT OF MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		PLE CONSTRUCTION (1911)	(X3) DATE SU	JRVEY TED
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F 221	to get up or lean forwaremoved during the m	no attempts by the resident ard. The lap buddy was not leal.	F	221			
	p.m. at Nursing Statio wheelchair with her fe was sitting upright and	oserved on 9/7/11 at 4:00 n A propelling the let and hands. The resident d was able to reposition let as secured to the resident's			1		
	p.m. The resident was member. A lap buddy resident's wheelchair. buddy was a cup with	Resting on top of the lap a red drink. Nurse # 2 to remove the lap buddy the					
	1 indicated that the re the lap buddy was use	n 9/9/11 at 10:42 a.m., NA# sident had several falls and ed as safety measure. Also to wear the lab buddy t of bed.	***************************************				100000000000000000000000000000000000000
	9/9/11 at 2:00 p.m., sh was not care-planned lap buddy was not a re coordinator added tha	th the MDS coordinator on the stated that the resident for a restraint because the estraint. The MDS the resident was given the ecause of her many falls.		A A A A A A A A A A A A A A A A A A A			
	indicated that dementi medical reasons for th She further stated that walk and, because of	9/11 at 3:30 p.m., DON a and poor safety were the e resident's lap buddy. the resident was unable to the falls, she gave the . The DON added that she	- Andrews - Andr				

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NA# 10, she stated that the resident had the lap buddy for her safety whenever she was in the wheelchair. She indicated that the resident cannot walk, she needs the lap buddy for positioning, and she puts her drinks and phone on it.

During an interview on 9/9/11 at 6:00 p.m., the Rehab Director indicated that Resident #100 had been seen by the department for chest therapy, bed mobility, and gait training; she was never referred to the department for any positioning device. The rehab director indicated that the department staff was not involved in the quarterly review process for the use or discontinuation of

Event ID: W46R11

Facility ID: 923208

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CONTRACTOR OF THE SERVICES CONTRACT

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NAME OF PR	ROVIDER OR SUPPLIER		•	s	TREET ADDRESS, CITY, STATE, ZIP CODE			
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F 221	implements the restricted request. 3. Resident #84 was 4/24/08 with the diagonal hypertension and and Review of quarterly Mated 7/11/11 indicated short and long term in severely impaired cog decision making the Mad no mood indicated during the seven day MDS indicated the rephysical assistance of daily living except eat wheel chair. The MD was unsteady with gassistance. The MD that the resident had Review of the physici Effective 5-26-08 per recommendation -PT, high back w/c(wheeld remind pt(patient) not was a thick pillow that wheelchair to prevent up. The most recent pt 8/1/11, May be up in grecliner) for position/c Out of bed in reclined wedge cushion leg resident in the side of the process of the physicial process.	ded that the nurse normally ctive devices at the family's admitted to the facility mosis of dementia, emia. Ininimum Data Set (MDS), ed Resident #84had severe memory problems, with gnitive skills for daily MDS indicated the resident was with disruptive behavior whook back period. The esident required extensive of two people with activities of thing and mobility while in S indicated Resident #84 with and required staff S assessment indicated no restraints. ans order dated 6/10/08, "P.T. (physical therapy) to be oob (out of bed) in their) with lap buddy to be open to get up. "A lap buddy to be a resident from standing the standing of the standin	F	:				
		urrent Restraint ment for a Physical Device						

PRINTED: 09/27/2011 THE THE THE ALL FORMAPPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES TO A SERVICE STATE OF THE SERVICES TO A SERVICE STATE OF THE SERVICES TO A SERVICE STATE OF THE SERVICES TO A SERVICE STATE OF THE SERVICES TO A SERVICE STATE OF THE SERVICES TO A SERVICE STATE OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING C B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 13 F 221 Form dated 1/15/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom to use the restraint was " Resident slides in w/c(wheelchair) and cannot remember to sit up d/t(due to) dementia ". Review of the most current Interdisciplinary Referral to Rehab/Quarterly Rehab Screen, dated 7/8/11, indicated change of Resident #84 condition "positioning /bed mobility" recommended occupational therapy evaluation. Review of an newly completed Restraint Initial/Annual Assessment for a Physical Device Form dated 9/9/11, was completed by the Director of Nursing and indicated Resident #84 medical symptom for use of the restraint, ' DX(diagnosis) muscle weakness and OA (osteoarthritis) abnormality. Res.(Resident) is not able to stand indep. (independently) safely, inc (increased) risk for falls, impaired balance. " Documented indicated no other options were attempted. Review of the Care Area Assessment, (CAA) dated 9/9/11, no trigger for restraints, review of the care plans revealed there was no care plan for restraints.

abnormality was observed.

During an observation on 9/9/11 at 12:45pm, Resident #84 ate her meal unassisted in the dining room. She sat in a high backed wheel chair at the table, no lap buddy a tab alarm in place (an alarm that was clipped to the residents clothing and chair that alarms when

disconnected) and an wandergard alarm(this alarm sounded when breeching the exit) on her wheel chair. Her positioning was upright, no

During an observation on 9/9/11 at 1:10pm,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THOSPIRATION OF HEALTH AND HUMAN SERVICES FOR THOSPIRATION OF THE PROPERTY OF THE FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF COMPANIES OF SECTION (X3) DATE SURVEY A 12 YEARS AND PLAN OF CORRECTION IDENTIFICATION NUMBER: -COMPLETED :: A. BUILDING C B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 14 F 221 Resident #84 was sitting in the dining room with the lab buddy in place. During an observation on 9/9/11 at 3:06pm, Resident #84 was sitting in the hall with the lap buddy in place the assistant director of nursing Filter to mid-face (ADON) requested her to remove the lap buddy. Resident #84 was unable to remove the lap buddy despite two requests by the ADON. Resident #84 said "I can't it is hooked on both sides " and after the second request " I can ' t. " The care plans were reviewed. No care plan was written to address the lap buddy use as a restraint, or reduction measures which had been attempted. A care plan dated 1/31/11 indicated the problem as, Alteration ADL(activities of daily living) r/t(related to) dementia with short and long term memory loss. The goal were as follows, 1. she will assist with turning and repositions self x 90 days. 2. she will be able to wash her face, 3. she will ambulate with 2 person assist. The approaches the facility would use to reach those goals were *Bath/shower as scheduled *Nail Care prn*Turn as reposition as indicated *Assist with clothing changes *Plate guardwith meals, * oob(out of bed)in recliner highback w/c with wedge cushion and leg rest with lap buddy

unassisted *

injury x90 days.

needed.

with postural correction, * feed at meal time if,

r/t impaired mobility she takes an

Care plan #2 relating to the use of the lap buddy, dated 1/31/11, the problem was Potential for falls

antiderpressant(sic)/antipsychotic, and anxiety. She had a fall 12/3/10. The goal *No fall related

Approaches keep bed low, call light within reach, maintain safety with transfers *Tabs monitor to alert staff and to remind patient not to set up

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION A SAME AND A SAM	(X3) DATE SURVEY		
•		345124	B. WIN	lG			C 9/2011
	ROVIDER OR SUPPLIER E HEALTHCARE OF ELK	IN - ·		5	REET ADDRESS, CITY, STATE, ZIP CODE 160 JOHNSON RIDGE RD ELKIN, NC 28621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE	Ð BE	(X5) COMPLETION DATE
F 221	twice), *Lap buddy in high back w.c * Bring Monitor s/sx (signs an tract infection) check I she can remove it 3/27/11 Fall, keep in v 3/31/11 Add to active which falls are monito Fall, Redirect if reside 5/17/11 Fall, toilet afte During an interview w on 9/9/11 at 1:10pm, I her lap buddy for posi on it. She indicated th get up by herself and to remove the lap bud wandergard would loc feet of the exit if the dwas open the alarm w indicted the tab alarm falls. During an interview or indicated the lap budd of the wheelchair. She cannot get out of her collide out of the wheelchair and a sticky diyoc cushion and the chair	all times(it was written chair to aid in position with out of room if restless. * d symptoms) uti (urinary ap buddy frequesnt ly as riew of staff when up in w/c occ program (a program in red for a month) 4/10/11 nt goes off unit. It suppers the Director of Nursing revealed Resident #84 used thought and to set her coffee the resident was not able to could not walk and was able dy. She revealed the k the outside door within 6 for were shut, if the door ould sound. She also was in place to prevent 19/9/11 at 2:48pm, NA# 7 y kept her from falling out explained Resident #84 thair or walk, but she can thair. A blue cushion in the em put between the prevented Resident #84	·	221			
	from sliding out of the thought the resident we buring an interview or indicated the primary rays to keep her from s	chair, she indicated she					

OLPAR FRANCES NEW PRINTED: 09/27/2011 FORM APPROVED AND REPUBLIC CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY SERVICE AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING C B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD HERITAGE HEALTHCARE OF ELKIN **ELKIN. NC 28621** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 221 Continued From page 16 F 221 chair. The personal alarm doesn't go off until she leans really far forward or she stands. NA#8 indicated Resident #84 doesn't stand well even with two people assisting her, and resident was unable to get up unassisted. She has not had any erema ocurer ale emilia recent fails. During an interview on 9/9/11 at 3:14 pm, NA# 9 indicated she had never seen Resident #84 remove her lap buddy. She indicated the purpose of the lap buddy was to keep her from sliding out of the wheel chair. She indicated there was another cushion in the chair to keep her in the chair, she indicated even with the lap buddy Resident #84 would slide under it up to her breast and indicated the resident was unable to stand or ambulate. During an interview on 9/9/11 at 3:30 pm, the physical therapy manager revealed Resident #84 sacral sits, (sits on her lower back and arches her back) to prevent sliding she currently had in place a wedge cushion which was higher in the front and lower in the back and a high back chair making it harder for her to slip out of the chair

broda chair.

when she arches her back. This adaptive

equipment did not prevent the sliding from sacral sitting, the lap buddy was an alternative, not the best alternative. Resident #84 was a good candidate for a broda chair (a low sitting reclined wheeled chair). She indicated she was unsure as to the reason the facility was unable to obtain a

During an interview on 9/9/11 at 4:35pm, NA #10 indicated the lap buddy was used to keep Resident #84 in her chair and that the resident was unable to get up out of her wheel chair or

	RS FOR MEDICARE & TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	fi Tipi F	CONSTRUCTION Water \$5 43 ACC G TO 11 2871	1	0. 0938-0391 RVEY HUNDLIN
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		* 1 * 1 * 1 * 1 * 1 * 1 * 1 * 1 * 1 * 1	COMPLET	ED 24 THE DOLL
		345124	B. WIN	G			C 9/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET	T ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE HEALTHCARE OF ELK	KIN			JOHNSON RIDGE RD LIN, NC 28621		
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	walk without staff ass her remove it; she incit, thinking it is her pu During an interview o occupational therapis sacral sits,(sits on the chair would be most a doesn't have this type the facilities alternative 483.20(b)(1) COMPR ASSESSMENTS The facility must concar comprehensive, accomprehensive, accompreh	istance. She had not seen licated Resident #84 unzips rse. In 9/9/11 at 4:59pm, the interpretation of the lower back) and a broda appropriate. The facility of chair the lap buddy was re. EHENSIVE		272	1. Corrective action hat accomplished for the deficient practice for 134,100, and 84 through reevaluation and reactive necessity for physical device of physical device determined based or resident needs and substitutions recorrespondingly in the contraction.	e alleged Resider pugh ssessments essments es was n individus such ded	ent of evices. s, the ual
	resident assessment by the State. The ass least the following: Identification and den Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior particular	dent's needs, using the instrument (RAI) specified sessment must include at nographic information; atterns; ng; and structural problems; d health conditions;			2. Residents with the po- affected by the allege practice were identified 100% audit of resident assessed need for sat All residents with safe place were reassessed assessments documed least restrictive deviced implemented, and indi- plans and physician's amended to accurated changes.	ed deficited throughts with a fety deviced with ented, the fividual corders	ent gh gh ana rices. es in e

Medications;

Special treatments and procedures;

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	1' '		PLE CONSTRUCTION (1992) A PART SET SEX BUT, MO (1997) A PART SET SET SET SET SET SET SET SET SET SE	COMPLET		no ejeron Proces
		345124	B. WIN	IG_			9/2011	. •.
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F 272	Discharge potential; Documentation of sur the additional assessi areas triggered by the Data Set (MDS); and	nmary information regarding ment performed on the care completion of the Minimum ticipation in assessment.	F	272	The results of monitoring reviewed weekly in morn meeting and monthly dur meetings. Adjustments wimplemented as necessa on the results of monitorinensure compliance.	ing Ing PI ill be ry based	j∰13-11	, .
	by: Based on record revifacility failed to complete restraint RAP's (resident that were triggered for	is not met as evidenced ew and staff interview, the ete a full assessment for ent assessment protocols) r 3 of 4 resident's (10 and #84). The findings	-					
	11/5/09. Resident #13 included dementia, ce congestive heart failul weakness and degene quarterly Minimum Da 8/17/11, indicated that short and long term m	erative joint disease. The lita Set (MDS) dated t Resident #134 had severe lemory and decision making of the MDS was not coded	in in in		····)	ma , , , , , , , , , , , , , , , , , , ,		
	8/17/11, (restraints) no #134 did not have a la wheelchair. There was	iggers) worksheet dated otes indicated that Resident in buddy in place in her is nothing checked under the ion "section of the page.						

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.1.795 ft.*

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E HEALTHCARE OF ELF SUMMARY ST. (EACH DEFICIENC	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345124 SIN ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	1 1	STREE 560 ELK	T ADDRESS, CITY, STATE, ZIP CODE JOHNSON RIDGE RD KIN, NC 28621 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	(X3) DATE SU COMPLE 09/C	C (X5) COMPLETION DATE	100 (100 (100 (100 (100 (100 (100 (100
F 272	In addition, under each for each triggered RA whether the identified in the care plan. During an interview of MDS coordinator indices assessed the resident and the restraint assessor. The added the indicated they wanted added that the restraint not seen the resident lear added that use and from was not care plan bear estraint. Therefore, the not done. 2. Resident #100 was 10/1/09, with multiple hypertension, hypothy syndrome dementia, osteoarthritis. The sign assessment dated 6/2 resident had memory problems and needed bathing and limited as ambulation. There was The quarterly MDS (Massessment dated 8/2 resident had no restraint estimated the resident assistance with activity mobility, ambulatory,	ch individual RAP worksheet P, there was no indication problem was to be included In 9/9/11 at 1:10PM, the cated that when she t the lap buddy was in place essment had been done on at the resident and the family If the lap buddy. She further int was not coded on the im did not determine the lap is She indicated that she had remove the lap buddy, only in on the lap buddy. She equency of the lap buddy cause it was not coded as the care area triggers were is admitted to the facility on diagnoses including proidism, organic brain depression, anxiety and inficant change in status 29/11 indicated that the and decision-making I extensive assistance with is sistance with transfers and is no mention of restraint. Inimum Data Set) 22/11 indicated that the aints. The MDS also required extensive ties of daily living, transfers,	F	272	DEFICIENCY)			

File DEPARTMENT OF HEALTH AND HUMAN SERVICES From For CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI			(X3) DATE SU COMPLET	RVEY/HULLY CO
			345124	B. WIN	G_	·		9/2011
		ROVIDER OR SUPPLIER E HEALTHCARE OF ELK	KIN	•	STREET ADDRESS, CITY, STATE, ZIP COI 560 JOHNSON RIDGE RD ELKIN, NC 28621		CODE	
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	F 272	The physician's order " D/c [discontinue] se	e 20 dated 1/6/11 documented: atbelt to wheel chair. 2. May heelchair due to positioning	F:	27	2		
er er er		showed the resident varietraint. The CAT (can dated 8/3/11, (restrain Resident #100 did not her wheelchair. There under the "Care Planthe page. In addition, worksheet for each tri	at care plan dated 8/3/11 was not care-planned for a are area triggers) worksheet ints) notes indicated that it have a lapbuddy in place in was nothing checked inning decision "section of under each individual RAP aggered RAP, there was no is identified problem was to e plan.					
- (÷	p.m. The resident was member. A lap buddy resident's wheelchair. buddy was a cup with asked Resident #100 resident did not remove During an interview or 1 indicated that the rethe lap buddy was use	Resting on top of the lap a red drink. Nurse # 2 to remove the lap buddy the ve the lap buddy. n 9/9/11 at 10:42 a.m., NA# sident had several falls and led as safety measure. Also					
THE REPORT OF THE PARTY OF THE		During an interview wi 9/9/11 at 2:00 p.m., sh was not assessed for buddy is not a restrain added that the resider	ith the MDS coordinator on ne stated that the resident a restraint because the lap at. The MDS coordinator nt was given the lapbuddy ther many falls. She added					

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	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	1	NSTRUCTION AND AND AND AND AND AND AND AND AND AN		URVEY.
	·	345124	B. WING	3		09/	C 09/2011
	ROVIDER OR SUPPLIER E HEALTHCARE OF ELK	GN		560 JOH	DDRESS, CITY, STATE, ZIP CODE HNSON RIDGE RD		
				ELKIN,	, NC 28621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	buddy. She further ad	21 Ided that the restraint was S because the team did not	F 2	272			
!	determine the lap bud						
	indicated that dement medical reasons for th further stated that the and, because of the fa the lap buddy. The DO	dmitted to the facility			· · · · • • • • • • • • • • • • • • • •		
- ::.	hypertension and ane Review of quarterly Mated 7/11/11 indicates short and long term meseverely impaired cog decision making. The indicated she required transferring, walking, opersonal hygiene and assist locomotion on the and off the toilet and be P, indicated "0", no Review of the physicial Effective 5-26-08 per Frecommendation -PT. high back w/c (wheelc	mia. finimum Data Set (MDS), d Resident #84 had severe emory problems; with nitive skills for daily MDS section "G" extensive assistance dressing, toilet use, bathing and one person he unit, eating, transfer on hetween surfaces. Section restraints were in use. in's order dated 6/10/08, " P.T. (physical therapy) to be oob (out of bed) in hair) with lap buddy to			; · · · · · · · · · · · · · · · · · · ·	· ,	
	was a thick pillow that wheelchair to prevent : The most recent physi May be up in geri chail position/comfort. Fall p	to get up. " A lap buddy was hooked to the a resident from standing up cian's order dated 8/1/11, r (a wheeled recliner) for precautions. Out of bed in elchair with wedge cushion					

leg rests applied lap buddy with postural

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`	ULTIPLE LDING-	CONSTRUCTION DESCRIBERS AND ACCESSOR OF THE SERVICE AND AC	(X3) DATE SURVEY MECHANISM COMPLETED MARKET COMPLETED	
		345124	B. WIN	IG		09/09/2011	٠.
	ROVIDER OR SUPPLIER E HEALTHCARE OF ELK	in		560	T ADDRESS, CITY, STATE, ZIP CODE JOHNSON RIDGE RD (IN, NC 28621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 272	all times. Review of the most of Initial/Annual Assessiform dated 1/15/11, and Director of Nursing armedical symptom to use Resident slides in w/o remember to sit up d/indicated Resident #8 and bladder. Care plan dated 1/31 alternation in ADL levishort and long term in OOB in recliner high licushion and leg rest accorrection. Care plan dated 1/31 potential for falls due fall a 12/3/10. Approach in to aid in position wheelchair. Review of an newly of Initial/Annual Assessiform dated 9/9/11, with Director of Nursing armedical symptom for DX(diagnosis) muscle osteoarthritis) abnormable to stand indep. (increased) risk for fall indicated Resident #8 and bladder. Review of the Care A dated 9/9/11, did not in restraints, review of the was no care plan for restraints, review of the was no care plan for restraints.	derguard on wheel chair at urrent Restraint ment for a Physical Device was completed by the id indicated Resident #84 use the restraint was " is (wheelchair) and cannot it (due to) dementia " and id was incontinent of bowel /11, problem identified el related to dementia with memory loss. Approach, boack wheelchair with wedge with lap buddy with postural /11, problem identified to impaired mobility and a maches included, lap buddy in ming with high back completed Restraint ment for a Physical Device as completed by the ind indicated Resident #84 use of the restraint, " weakness and OA(mality. Res. (Resident) is not independently) safely, inc ls, impaired balance " and 4 was incontinent of bowel rea Assessment,(CAA) dentify Resident #84 for ine care plans revealed there	F	272			

PRINTED: 09/27/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES MAN TO AN ARRANGE OF THE A CENTERS FOR MEDICARE & MEDICAID SERVICES OMB.NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA 10 2 3 5 5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A. BUII	LDIN	G - Sent of the Control of the Contr	COMPLET	RVEY (1.194.36.8) ED TOTAL TOTAL
		345124	B. WIN	IG		09/0	9/2011
	OVIDER OR SUPPLIER E HEALTHCARE OF ELK	in -	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 272	Resident #84 was sitt buddy in place the as (ADON) requested he Resident #84 was unabled buddy despite two received as an after the sides " and after the During an interview of indicated the lap buddy of the wheelchair. She cannot get out of her slide out of the wheelchair and diycem (a slipping) put between prevented Resident #During an interview of indicated the primary was to keep her from she had no lap buddy chair. The personal at she leans really far for indicated Resident #8 with two people assis on 9/9/11 at 3:14 pm, never seen Resident she indicated the pur to keep her from slidir She indicated there we chair to keep her in the with the lap buddy Reunder it up to her breat resident was unable to During an interview of indicated the lap buddy andicated the lap buddy and and and and and and and and and and	ing in the hall with the lap sistant director of nursing or to remove the lap buddy. The provided sistant director of nursing or to remove the lap buddy. The provided sistant director of nursing or to remove the lap quests by the ADON. I can't it is hooked on both second request "I can't." In 9/9/11 at 2:48pm, NA# 7 by kept her from falling out explained Resident #84 chair or walk, but she can chair. A blue cushion in the sticky pad to prevent the cushion and the chair 84 from sliding out. In 9/9/11 at 2:54pm, NA#8 reason for the lap buddy sliding out of the chair. If she would scoot out of the arm doesn't go off until rward or she stands. NA#8 4 doesn't stand well even ting her. During an interview NA# 9 indicated she had #84 remove her lap buddy, pose of the lap buddy was ag out of the wheel chair, as another cushion in the e chair, she indicated even sident #84 would slide ast and indicated the ostand or ambulate. In 9/9/11 at 4:35pm, NA #10 by was used to keep		272	another trees		
;	was unable to get up	nair and that the resident out of her wheel chair or stance. She had never					

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PRINTED: 09/27/2011

OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		E CONSTRUCTION CHARMED COMPAGE AND COMPAGE		RVBY: Cushosses / ED Digital J. Au-
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		345124	B. WING	ن		09/0	9/2011
l .	OVIDER OR SUPPLIER E HEALTHCARE OF ELK	IN		560	ET ADDRESS, CITY, STATE, ZIP CODE D JOHNSON RIDGE RD KIN, NC 28621		
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F 278 SS=D	During an interview w 9/9/11 at 2:00 p.m., si was not assessed for buddy was not a restrin the wheelchair. Dur at 5:37pm, at the MDS had intertwined the lawith falls and cognitive asses the lap buddy at 483.20(g) - (j) ASSES ACCURACY/COORD. The assessment must resident's status. A registered nurse must each assessment with participation of health. A registered nurse must assessment is complete assessment is complete assessment must sign that portion of the assessment in a resubject to a civil mone \$1,000 for each assess willfully and knowingly to certify a material and resident assessment in penalty of not more thassessment.	ith the MDS coordinator on the stated that the resident a restraint because the lap aint; it was used to keep her ring an interview on 9/9/11 is coordinator indicated she published by buddy in the care plan as a restraint. SMENT INATION/CERTIFIED it accurately reflect the last conduct or coordinate in the appropriate professionals. Inst sign and certify that the sted. In and certify the accuracy of essment. Medicaid, an individual who certifies a material and esident assessment is an entire of the sent of the sent of the causes another individual diffuse statement in a subject to a civil money an \$5,000 for each	F 2		Corrective action has bee accomplished for the alleg deficient practice for Residual 134,100, and 84 through reevaluation and reassess of the necessity for physical devices. Based on the reassessments, the use of physical devices was detended appropriately in clinical record. Residents with the potent affected by the alleged depractice were identified the 100% audit of residents wassessed need for safety	ged dents # sment cal of ermined ent ations the ial to be eficient brough	9-22-1
	Clinical disagreement	does not constitute a					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION 19 19 19 19 19 19 19 19 19 19 19 19 19	SURVEY: 30 (0.777) 1 1 LETED 1000 870 1 (1910
·		345124	B. WING_	01	C 9/09/2011
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F 278	Continued From page material and false state		F 278	with assessments documented,	d 9-22-4
	by: Based on observation review the facility faile information on the Min	imum Data Set (MDS) I residents with restraints(the least restrictive device implemented, and individual care plans and physician's orders inconsistencies or problems with device use.	
	Findings include:	·		The results of monitoring will be reviewed weekly in morning	10-13-11
· · · · · · · · · · · · · · · · · · ·	11/5/09. Resident #13/included dementia, cer congestive heart failure weakness and degene quarterly Minimum Dat 8/17/11, indicated that short and long term me	rative joint disease. The la Set (MDS) dated Resident #134 had severe emory and decision making the MDS was not coded		meeting and monthly during PI meetings. Adjustments will be implemented as necessary based on the results of monitoring to ensure compliance.	
•	lap buddy for safety an no medical symptom in has been in restorative	dated 8/7/11, documented d positioning. There was dicated. Resident #134 ambulation 15 minutes 2010. There was only on 3/11.			P. W. C. C. C. C. C. C. C. C. C. C. C. C. C.
	The CAT (care area trig 8/17/11, (restraints) not #134 did not have a lap wheelchair.	es indicated that Resident			
	During an interview on the MDS coordinator indicates				

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	OF DEFICIENCIES 425 CORRECTION 425	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION:	COMPLET	RVEY TISTABLERS ED STROTTES S C	
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F 278	was in place and the abeen done on 8/7/11. and the family indicate buddy. She further ad not coded on the MDS determine the lap bud indicated that she had remove the lap buddy on the lap buddy. She frequency of the lap because it was not cothe care area triggers problem area under fa #134 had a lap buddy for placing her cup on 2. Resident #100 was 10/1/09, with multiple hypertension, hypothy syndrome dementia, costeoarthritis. The sig assessment dated 6/2 resident had memory problems and needed bathing and limited as ambulation. There was model to resident had no restra revealed the resident assistance with activiti mobility, ambulatory, shalance, and required There was no mention	estraint assessment had She added that the resident ad they wanted the lap ded that the restraint was because the team did not dy was a restraint. She I not seen the resident I only seen the resident lean I added that use and I uddy was not care plan ded as restraint. Therefore, were not done. The I sills indicated that Resident In place for positioning and admitted to the facility on diagnoses including roidism, organic brain lepression, anxiety and inficant change in status 9/11 indicated that the and decision-making extensive assistance with sistance with transfers and s, no mention of restraint. I inimum Data Set) 2/11 indicated that the ints. The MDS also required extensive es of daily living, transfers, standing and sitting, one-person assistance.	•	278				The second of
	" D/c [discontinue] sea	tbelt to wheel chair. 2. May				<u>-</u>		

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PRINTED: 09/27/2011 DE THE WENT OF HEAL FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES ** OMB NO. 0938-0391 STATEMENT: OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIONS A LERGEST AND ADDRESS. (X3) DATE SURVEY HEREINE OFFICE SERVICE AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED TENTS OF A. BUILDING C B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 278 Continued From page 27 F 278 use [lap buddy] in wheelchair due to positioning issues. " Review of the medial record revealed a quarterly MDS assessment 8/2/11. Under the MDS. . 124.5 section "PO100. Physical Restraint" trunk," the facility indicated, "0". None. Resident #100 was observed on 9/9/11 at 12:30 p.m. The resident was in her room with a family member. A lap buddy was secured to the resident's wheelchair. Resting on top of the lap buddy was a cup with a red drink. Nurse # 2 asked Resident #100 to remove the lap friend, the resident could not remove the lap buddy. During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was coded "O" for a trunk restraint because the lap buddy is not a restraint. The MDS coordinator added that the resident was given the lap buddy for safety because of her many falls. 3. Resident #84 was admitted to the facility 4/24/08 with the diagnosis of dementia, hypertension and anemia. Review of guarterly Minimum Data Set (MDS), dated 7/11/11 indicated Resident #84 had severe

short and long term memory problems; with severely impaired cognitive skills for daily decision making. The MDS section "G" indicated she required extensive assistance transferring, walking, dressing, toilet use, personal hygiene and bathing and one person assist locomotion on the unit, eating, transfer on and off the toilet and between surfaces. Section P, indicated "0", no restraints were in use. Review of the physician's order dated 6/10/08, " Effective 5-26-08 per P.T. (physical therapy)

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345124	1	LDING	CONSTRUCTION, DARK MARKA O FRANCISCO. And the optimization of the	(X3) DATE SUI COMPLET	RVEY THE MEETS ED TELEFORMS C 9/2011	unskirt krijus Graden angara Kalanda
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F 278	high back w/c (wheel remind pt (patient) no was a thick pillow that wheelchair to prevent The most recent phys May be up in geri chaposition/comfort. Fall reclined highback whileg rests applied lap to correction noted War all times. Review of the most of Initial/Annual Assession of Nursing at medical symptom to the Resident slides in w/c remember to sit up d/indicated Resident #8 and bladder. Care plan dated 1/31 alternation in ADL levishort and long termino OOB in recliner high cushion and leg rest correction. Care plan dated 1/31 potential for falls due fall a 12/3/10. Approach to aid in position wheelchair. Review of an newly of Initial/Annual Assession dated 9/9/11, wincretor of Nursing at	to be oob (out of bed) in chair) with lap buddy to at to get up. "A lap buddy to to to get up. "A lap buddy to twas hooked to the a resident from standing up sician's order dated 8/1/11, air (a wheeled recliner) for precautions. Out of bed in eelchair with wedge cushion buddy with postural derguard on wheel chair at current Restraint ment for a Physical Device was completed by the and indicated Resident #84 ase the restraint was "as (wheelchair) and cannot at (due to) dementia "and and a was incontinent of bowel 1/11, problem identified are related to dementia with the memory loss. Approach, back wheelchair with wedge with lap buddy with postural 1/11, problem identified to impaired mobility and a caches included, lap buddy in an another included, lap buddy in an another included as completed Restraint ment for a Physical Device as completed by the and indicated Resident #84 use of the restraint, "		278				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

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OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION C	(X3) DATE SURVEY COMPLETED C	
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F 278	able to stand indep. (i (increased) risk for fal indicated Resident #8 and bladder. Review of the Care Aldated 9/9/11, did not i restraints, review of the was no care plan for During an observation Resident #84 was sittle buddy in place the assets.	rality. Res. (Resident) is not independently) safely, inc ils, impaired balance " and 4 was incontinent of bowel area Assessment, (CAA) dentify Resident #84 for ille care plans revealed there estraints.	F	278			
	Resident #84 was una buddy despite two red Resident #84 said "I sides " and after the sides " and after the sides " and after the sides " and after the sides " and after the sides " and after the sides " and interview or indicated the lap budd of the wheelchair. She cannot get out of her calide out of the wheelchair and diycem (a silpping) put between prevented Resident #8 During an interview or	able to remove the lap quests by the ADON. can 't it is hooked on both second request "I can't." n 9/9/11 at 2:48pm, NA# 7 ity kept her from falling out explained Resident #84 chair or walk, but she can chair. A blue cushion in the ticky pad to prevent the cushion and the chair	-				
	was to keep her from a she had no lap buddy chair. The personal all leans really far forward indicated Resident #8 with two people assist on 9/9/11 at 3:14 pm, never seen Resident #8 She indicated the purp to keep her from sliding	sliding out of the chair. If she would scoot out of the arm doesn't go off until she	,				

PRINTED: 09/27/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· i	,	PLE CONSTRUCTION (C. C.	(X3) DATE S	TED TO A PTO CT
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F 278	with the lap buddy Reunder it up to her brea resident was unable to During an interview or indicated the lap budd Resident #84 in her chwas unable to get up owalk without staff assisseen her remove it. During an interview wi 9/9/11 at 2:00 p.m., shwas not assessed for a buddy was not a restrain the wheelchair. Duri at 5:37pm, at the MDS had intertwined the lap	e chair, she indicated even sident #84 would slide st and indicated the st and or ambulate. In 9/9/11 at 4:35pm, NA #10 by was used to keep nair and that the resident out of her wheel chair or stance. She had never the the MDS coordinator on the stated that the resident a restraint because the laphaint; it was used to keep her not an interview on 9/9/11 coordinator indicated she buddy in the care plan impairment, and did not	F	278	No other control of the control of t		
SS=D	The resident has the ri- incompetent or otherwi- incapacitated under the participate in planning changes in care and tre A comprehensive care within 7 days after the comprehensive assess interdisciplinary team, to physician, a registered for the resident, and oth disciplines as determine and, to the extent pract the resident, the reside	ght, unless adjudged se found to be e laws of the State, to care and treatment or eatment. plan must be developed completion of the ment; prepared by an hat includes the attending nurse with responsibility	F2	280	1.3.5 3 arrandare in	enderse rakkine ne	COUNTY .

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		345124	B. WIN			1	C 9/2011
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F 280		31 n of qualified persons after	F:	280			
	by: Based on observation reviews, the facility fa 4 of 4 residents with r including the frequence (Resident #134, #100 included) 1. Resident #134 was 11/5/09. Resident #13 included dementia, care congestive heart failunt weakness and degend quarterly Minimum Da 8/17/11, indicated that short and long term m problems. The MDS at #134 was hard of heat an assistive device ar understanding verbal, help make sense of the tone was not at an election P of the MDS of restraint. Resident stolleting program and but needed assistance ambulation.	admitted to the facility on 34 cumulative diagnoses prebral vascular accident, re, general muscle perative joint disease. The sta Set (MDS) dated at Resident #134 had severe permory and decision making also indicated that Resident ring and required the use of ad still had difficulty content and reminders to be things even when voice posted volume in one ear. It was not coded for the use #134 was involved in a had made some progress, as with transfers and				anny arterior	
	lap buddy for safety a	dated 8/7/11, documented nd positioning. There was ndicated. Resident #134					

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OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY. (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE:CONSTRUCTION WAS AMONOUSED ONE CONTROL STATEMENT: OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 32 F 280 has been in restorative ambulation 15minutes per day since January 2010. Review of the care plan dated 8/22/11, identified the problem as: 1. potential for falls r/t(related to) falls on 6/18/11(unobserved fall, Resident was found in room on floor) and 8/16/11staff was present in resident room she took off her lap buddy and stood up without assistance, gait unsteady, balance is impaired. The goal was Resident #134 will have no falls r/t(related to) injuries x 90 days. The approaches included remind resident to call for assist with transfers and/or ambulation, keep bed in low position at all times, call light within reach, maintain safety with transfers, remind resident to call for assist with transfers and to use her walker with ambulation, lap buddy, 2. Decline in ability to ambulate independently. The goal included Resident #134 will ambulate 50-125 ft daily x 90 days. The approach included the rolling walker with supervision and verbal cues to stand up tall stay close to rolling walker, monitor and document program. There was no indication on the care plan of the frequency and duration of use for the lap buddy. During an interview on 9/9/11 at 1:10PM, the MDS coordinator indicated that when she assessed the resident the lap buddy was in place and the restraint assessment had been done on 8/7/11. She added that the resident and the family indicated they wanted the lap buddy. She further added that the restraint was not coded on the MDS because the team did not determine the lap buddy was a restraint. She indicated that she had not seen the resident remove the lap buddy, only seen the resident lean on the lap buddy. She

PRINTED: 09/27/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES, SEED TO A PROSPECT A SEED TO A PROSPECT AND A PROSPECT HEALTHORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY- 112 A. I. (X2) MULTIPLE CONSTRUCTION OF A SECOND CONTROL OF A SECOND ROLL (X2) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING C B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **560 JOHNSON RIDGE RD** HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 33 F 280 added that use and frequency of the lap buddy was not care plan because it was not coded as restraint. Therefore, the care area triggers were not done. The lap buddy was in place for positioning and a place for Resident #134 to Control Consultation Control Consultation Co place items. 2. Resident #100 was admitted to the facility on 10/1/09, with multiple diagnoses including hypertension, hypothyroidism, organic brain syndrome dementia, depression, anxiety and osteoarthritis. The quarterly MDS (Minimum Data Set) assessment dated 8/22/11 indicated that the resident had no restraints. The MDS also revealed the resident required extensive assistance with activities of daily living, transfers, mobility, ambulatory, standing and sitting, balance, and required one-person assistance. The significant change in status assessment dated 6/29/11 indicated that the resident had memory and decision-making problems and needed extensive assistance with bathing and limited assistance with transfers and ambulation. There was no mention of restraint. The physician's order dated 1/6/11 documented: " D/c [discontinue] seatbelt to wheel chair. 2. May use 'Posey hugger' [lap buddy] in wheelchair due to positioning issues. " Review of the resident care plan dated 8/3/11 showed the resident was not care-planned for a

restraint.

Resident #100 was observed on 9/6/11 at 3:00 p.m. The resident was in her room. A lap buddy was secured to the resident's wheelchair.

On 9/7/11 at 8:40 a.m., resident #100 was

PRINTED: 09/27/2011 FORMAPPROVED! CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND ADDRESS OF THE PERSON OF THE (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION CONTROL AND CONTROL OF THE ACT (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD. HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 Continued From page 34 F 280 observed in her wheelchair in the dining room eating breakfast with the lap buddy in place. Observation revealed no attempts by the resident to get up or lean forward. The lap buddy was not removed during the meal. to conato auroca de a-Resident #100 was observed on 9/7/11 at 4:00 p.m. at Nursing Station A propelling the wheelchair with her feet and hands. The resident was sitting upright and was able to reposition herself. A lap buddy was secured to the resident's wheelchair. Resident #100 was observed on 9/9/11 at 12:30 p.m. The resident was in her room with a family member. A lap buddy was secured to the resident's wheelchair. Resting on top of the lap buddy was a cup with a red drink. Nurse # 2 asked Resident #100 to remove the lap buddy. The resident did not remove the lap buddy. During an interview with the MDS coordinator on 9/9/11 at 2:00 p.m., she stated that the resident was not care-planned for a restraint because the lap buddy is not a restraint because the resident is capable of removing the lap buddy. The MDS

hypertension and anemia.

coordinator added that the resident was given the lap buddy for safety because of her many falls.

4.Resident #84 was admitted to the facility

4/24/08 with the diagnosis of dementia,

Review of Minimum Data Set (MDS), dated 7/11/11 indicated Resident #84 had severe short and long term memory problems; with severely impaired cognitive skills for daily decision making. The MDS section "G" indicated she required extensive assistance transferring, walking,

	OF DEFICIENCIES************************************	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345124	A. BUI	LDING	CONSTRUCTION CROWN SHAPE OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	COMPLET	RVEY (1000031) ED (1001058) C 9/2011
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F 280	dressing, toilet use, prand one person assis eating, transfer on an surfaces. Mobility dev wheelchair. Section hincontinent of bladder always continent of befalls. Section P, indictivere in use. Review of the physicial Effective 5-26-08 per recommendation -PT. high back w/c (wheelchemind pt (patient) not was a thick pillow that	ersonal hygiene and bathing t locomotion on the unit, d off the toilet and between rices included a walker and H indicated always. Section I indicated owel. Section J, indicated no ated "0", no restraints an's order dated 6/10/08, "P.T. (physical therapy) to be oob (out of bed) in chair) with lap buddy to t to get up. "A lap buddy was hooked to the a resident from standing	F	280		550 (\$7 v)III	to samp delizar on
C.	Initial/Annual Assessm Form dated 1/15/11, v Director of Nursing an medical symptom to u Resident slides in w/c remember to sit up d/t indicated Resident #8- and bladder. Care plan dated 1/31/ alternation in ADL leve short and long term m OOB in recliner high b	nent for a Physical Device was completed by the d indicated Resident #84 se the restraint was " (wheelchair) and cannot (due to) dementia " and 4 was incontinent of bowel			į		

STATEMENT		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE COI	NSTRUCTION: (4.6% Light for 1.1% for 1.6% light for 1.1% for 1.1% light for 1.1% for 1.1% light	(X3) DATE S	IO. 0938-039 URVEY TAXABLE ETED TO STATE	
		345124	B. WIN			09/	C /09/2011	
,	ROVIDER OR SUPPLIER E HEALTHCARE OF ELK	an ···		STREET ADDRESS, CITY, STATE, ZIP CODE 580 JOHNSON RIDGE RD ELKIN, NC 28621				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 280	Continued From page fall a 12/3/10. Approachair to aid in position wheelchair.	sches included, lap buddy in	F2	280				
	Form dated 9/9/11, was Director of Nursing and medical symptom for a DX(diagnosis) muscle osteoarthritis) abnormable to stand indep. (in (increased) risk for fall indicated Resident #8 and bladder., Review of the Care Ardated 9/9/11, did not in	nent for a Physical Device as completed by the d indicated Resident #84 use of the restraint, " weakness and OA(ality. Res. (Resident) is not ndependently) safely, inc ls, impaired balance " and 4 was incontinent of bowel ea Assessment,(CAA) dentify Resident #84 for	-				actions described	
	During an observation Resident #84 was sitti buddy in place the ass (ADON) requested her Resident #84 was una buddy despite two req Resident #84 said ".I.a	on 9/9/11 at 3:06pm, ng in the hall with the lap istant director of nursing r to remove the lap buddy. ble to remove the lap	• • • •		ł · · · · · · · · · · · · · · · · · · ·			
	indicated the lap buddy of the wheelchair. She cannot get out of her calide out of the wheelchair and a sticky divos	9/9/11 at 2:48pm, NA# 7 y kept her from falling out explained Resident #84 hair or walk, but she can hair. A blue cushion in the em put between the prevented Resident #84		Account of the second of the s				

Patring as

Comprehension excellent		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		41 17 *	TIDLE CONSTRUCTION	7). 0938-0391	1
		F CORRECTION	IDENTIFICATION NUMBER:	A BU		TIPLE CONSTRUCTION (1949) (194	COMPLET	RVEY PROBABILITY ED PROCESSORY C	n ranger
	**		345124	B. WI	NG_			9/2011	No.
	·	ROVIDER OR SUPPLIER E HEALTHCARE OF ELK	in ·		s	STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621			
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	١X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	F 280	During an interview or indicated the primary was to keep her from she had no lap buddy chair. The personal all she leans really far for indicated Resident #8 with two people assist During an interview or indicated she had new remove her lap buddy of the lap buddy was to fithe wheel chair. She another cushion in the chair, she indicated ex Resident #84 would sl	n 9/9/11 at 2:54pm, NA#8 reason for the lap buddy sliding out of the chair. If she would scoot out of the arm doesn't go off until- rward or she stands. NA#8 4 doesn't stand well even ing her. n 9/9/11 at 3:14 pm, NA# 9 er seen Resident #84 . She indicated the purpose o keep her from sliding out e indicated there was	F					Tes en Menado
		indicated the lap budd Resident #84 in her ch was unable to get up of walk without staff assist her remove it. During an interview wire 9/9/11 at 2:00 p.m., sh was not assessed for a buddy was not a restration buring an interview on MDS coordinator indicate lap buddy in the care	the the manner of the the the the the the the the the the	F3	371	1			

	OF DEFICIENCIES	MEDICAID SERVICES			NO. 0938-0391
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	IPLE CONSTRUCTION DELICATION OF THE COMPLETE COMPLICATION COMPLETE COMPLICATION COMPLETE COMP	SURVEY N.C. ACTURY LETED COLOR OF COLOR COLOR OF COLOR OF CO
		345124	B. WING_		C
NAME OF P	ROVIDER OR SUPPLIER				/09/2011
HERITAG	E HEALTHCARE OF ELF	(IN		REET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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	authorities; and	sources approved or ry by Federal, State or local stribute and serve food	F 371	Heritage Healthcare of Elkin will proc food from sources Approved or considered satisfactory I Federal, State, or Local authorities and will store, prepa ,distribute and serve food	ру
	by: Based on observation record reviews, the far bowls, and 2) failed to	propriate temperature in	-	Under sanitary conditions Per dietary manager the bowls were drying on the rack and were not Used until they were completely dry. Did not need for noon meal)	9.8-11
ł	During the kitchen obs 11:40 a.m., 2 racks of green bowls were obse each other on a cart in kitchen. Water was rur dietary manager acknow the bowls, saying that ready to be used.	pervation on 9/8/11 at pink bowls and 3 racks of erved stacked on top of the dish room area in the aning off the bowls. The owledged the condition of they were clean, wet, and edietary aide on 9/8/11 at		CDM will re-educate dietary staff on proper drying techniques and Importance of not using until dishes is completely dry. The CDM and or designee will monitor compliance on daily basis	<i>10-14-1</i> 1

stored the bowls wet on the cart."

During the tray line observation on 9/8/11 at 11:53 a.m., there was no food for the residents

on the tray line. Upon further inspection, tuna

salad and pasta salads (foods prepared for

For 4 weeks then randomly thereafter.

The findings will be taken to PI

committee monthly times two

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011

CTATCMEN	* OF DEPLOY	I OLIVIOLO				OMB NO	<u>). 0938-0391</u>
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) M A. BUI				RVEY TO THE
		345124	B. WI	IG			0
	PROVIDER OR SUPPLIER GE HEALTHCARE OF ELK	in	I <u>"</u>	5	REET ADDRESS, CITY, STATE, ZIP CODE 60 JOHNSON RIDGE RD ELKIN, NC 28621	09/01	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	9/8/11 lunch) were obsertigerator and freeze	served in the walk-in or. The digital thermometer	F	371	The tuna and pasta salad was d and alternate substitute	iscarded	9-8-11
	11:55 a.m. were 46 de 58 degrees F for the p	mperatures recorded at grees F for tuna salad, and asta salad. The	e Die Wilham	3	Used in its place for lunch. The other thermometers were discarded a		9-8-11
	DM observed. The tensame for the tuna sala observations were made	checked immediately as the apperature remained at the dand pasta salad. Further de, and a large bowl of ed in the freezer with a			Regular thermometers are now dietary dept.	in use in	9.8-#
	thermometer in the mid recorded temperature tuna salad. At 12:15 p. rechecked: the tuna sa	ddle of the tuna salad. The was 44 degrees F for the m., the temperatures were lad was 44 degrees F, and			CDM and or designee will monit temps carefully and temps will		Douby
	the pasta salad was 55 degrees F. In an interview on 9/8/11 at 12:30 p.m. with the DM, she stated that the tuna salad and the pasta salad temperatures should be 40 degrees or below. She added that she does not know what happened. She added, "I believe the digital				Be recorded for each meal on ter Findings will be taken to the PI committee for followup monthly three		10-13-11
F 456 SS=D	are recording incorrect 483.70(c)(2) ESSENTIA OPERATING CONDITI	AL EQUIPMENT, SAFE	F 4	56		e investiga	
\$	The facility must mainta mechanical, electrical, a equipment in safe opera	in all essential, and patient care ating condition.			TIX () () () () () () () () () (o; non da	er tall conserver s
	This REQUIREMENT is by: Based on observations, department and staff into to ensure the oxygen co heating/air conditioning safe, operating condition	, interview with fire erviews, the facility failed ncentrators and (HVAC) units were in					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TE PENTET FORM APPROVED PARENT OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY 100 (C) STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION TO A 1999 A COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 345124 09/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 580 JOHNSON RIDGE RD HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 456 F 456 Continued From page 40 Staff upon noticing hot smell in room (room # 112, Resident # 100). Findings included. immediately removed patients During an observation on tour of the facility on From room, pulled fire alarm, called 911 9/6/11 at 2:00 p.m., the baseboard in Room 112 was torn away from the wall, and there was a and secured room. hole in the wall. The oxygen concentrator had a red lock (meaning do not use) on it, and the Each of the older PTAC units have been nebulizer was unplugged. replaced with new units In an interview on 9/6/11 at 1:30 p.m. with Nursing Assistant (NA #1;), she stated, "I heard PTAC units have been cleaned to a noise. Then the smoke alarm went off, and the minimize possible activation of call light for Resident #100 came on. I went into Resident #100 's room. The smoke alarm was on. There was the smell of something burning, Smoke detectors, filters changed monthly and the wall close to Resident #100 's oxygen concentrator (O2 concentrator) was hot. I Educate staff, families and patients for immediately turned off the resident 's O2 10-14-11 smell when unit is first turned on concentrator. I got her out of the room and told the other employees what was going on. I immediately sounded the fire alarm and And how it may set off the smoke announced Code Red. All the residents in that detector in room due to sensitivity of area were evacuated, and the fire department

In an interview on 9/6/11 at 1:45 p.m. with the interim Director of Nursing (DON), she stated that there was a smell of something burning in the resident's room (Room 112), and all the residents in that area were evacuated to the dining area. Families for the residents in Room 112 were notified that there was a malfunction with the equipment in the room, which triggered the smoke alarm, and the residents were moved to another room. " When asked by the surveyor if all the other oxygen concentrators were checked, she said, "I do not know; I believe housekeeping

came and inspected the room. "

Maintenance Supervisor keeps log of when units are cleaned and filters changed

Random audits performed by administrator and or designee

Findings will be taken to PI monthly times three

onlaus

alarm

DEPARTMENT OF HEALTH AND HUMAN SERVICES 产品表面。 CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF

PRINTED: 09/27/2011
FORM APPROVED: 15 (1975)
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		CLE CONSTRUCTION CONTRACT CONT	(X3) DATE SURVEY To be a work COMPLETED TO THE COMPLETED TO THE COMPLETED TO THE COMPLETE OF T			
		345124	B. WIN	IG_		1	9/2011	
	ROVIDER OR SUPPLIER E HEALTHCARE OF ELK	IN -	STREET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NC 28621			-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 456	Medical Record Mana Manager/Housekeepi that they heard the fire called to Room 112 by the smoke detector go room. "We went to to something hot, [so] we of the room. We reent and unplugged the he Code Red was annout the alarm was soundin Director came in and room. The fire departreminutes later and tore wall was hot to the too." They (the Medical Redietary Manager/Houst that the wall on the otte the residents were remained in the residents were remained in the residents were remained in the residents were remained in the residents were remained in the resident off, and I promptly were extinguisher, then I we then the resident off. The fire decident of the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident off. The fire decided in the resident of the O2 concentrator. The Maintena other O2 concentrator.	And the rooms." And the rooms." And the rooms." And the rooms. " And the rooms." And the room with the reger and Dietary and Manager, they stated the alarm sound and were by NA #1 with the report of room of the residents in the room and we smelled the room and we smelled the room [Room 112] the room the residents out red the room [Room 112] the room the facility and room the room th	F	456				
		Hankertant and Man		Ì				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OMB NO. 0938-0391							
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		LE CONSTRUCTION (AND MANY LOS (QUANTUM CONTROL	COMPLET	RVEY VORBER SY TED - ENTER A SECTION			
		345124	B. WIN	IG			C 9/2011	tres -		
	OVIDER OR SUPPLIER	in .		56	EET ADDRESS, CITY, STATE, ZIP CODE 0 JOHNSON RIDGE RD .KIN, NC 28621		0/2011			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 456	will be coming out 9/9	e out and check them. They /11. "	F	456						
e e	p.m. the Maintenance that " because the he first time for the summ elements were not cle came from the eleme He further added that during the summer, "	eaned, the burning smell ints and sounded the alarm." if the heaters were not used when they are turned on, ing smell to the point where it			and the second of the second o					
	smoke alarm went off the equipment and me evacuated the resider fire department came using the O2 concent	"Nothing happened; the there was a malfunction of y staff immediately hats to a safe place and the No one was in the room rator at that time."								
4	the Chief of the Fire E 9/5/11 he responded someone smelled sm was sounded in the fa was advised by staff to burning had been det room and that mainte electrical outlet facepl touch. We used a the room for any source opattern on the floor be outlet. We were informative the transformer located. We also check	n 9/7/11 at 12:07 p.m. with Department, stated that on to a call from the facility that oke and the smoke alarm solility. The fire department that "an odor of something ected in the residents 'nance had noticed that the ate appeared hot to the rmal imager to scan the of heat and detected a heat eneath and in an electrical med that this was the spot of for the oxygen device was exed the adjoining room for the walls. The only heat	,		į					

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	MENT OF HEALTH AN RS FOR MEDICARE & N	ND'HUMAN SERVICES MEDICAID SERVICES	ा अर्थन (देवने हि. -	~ Y =	Produce to the Control of the Contro		MAPPROVED 0. 0938-0391	
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		And the second of the second o	(X3) DATE SUF COMPLET	RVEY	
		345124	B. WIN	€			C 9/2011	
NAME OF PR	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 660 JOHNSON RIDGE RD			
HERITAGI	E HEALTHCARE OF ELK	IN		ELKIN, NC 28621				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ίX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X6) COMPLETION DATE	
F 456	electrical outlet in that the baseboard in the r possible fire, but no fir staff was advised that member of the fire derection the room of origin. "T staff " acted with safe in mind." During an interview or the Environmental Condition of the Environmental Condition of the Environmental Consultant when the units are turn burning smell and this detectors in the patien stated that the HVAC checking filters monthing the wall yearly, and do cleaning on the heating system. In an interview on 9/8/Administrator, when as concentrators and HV and what plans were in	at the floor level beneath the troom. We also removed from of origin to check for re was present. The facility the scene was clear. A partment remained on cal power was restored to the fire chief added that the ety and care of their patients 19/8/11 at 11:00 a.m. with insultant, he stated that itents 'rooms are not used for the year. The litant further stated that ined on for heat, there is a can set off the smoke its 'rooms. He further systems are maintained by ly, taking the units out of bing a complete service and it is a can set off the smoke its 'rooms. We further systems are maintained by ly, taking the units out of bing a complete service and its and air conditioning 111 at 12:00 a.m. with the sked how many O2 AC units were in the facility in place to prevent further ed she did not have a plan		456				
			l					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 10/10/2011 FORM APPROVED OMB NO, 0938-0391

ČENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCT!ON (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B, WING 10/04/2011 345124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 560 JOHNSON RIDGE RD HERITAGE HEALTHCARE OF ELKIN **ELKIN, NC 28621** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) KO18 Discloser Classe: Preparotion K 018 | NFPA 101 LIFE SAFETY CODE STANDARD andfor execution of the POC SS=F Doors protecting corridor openings in other than das not constitute admission required enclosures of vertical openings, exits, or of agreement by the provider of hazardous areas are substantial doors, such as the fruiths of the facts alleged or conclusion feet furth in those constructed of 1% Inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only the Statement of Octiviencies. required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors The Poc is prepared solely because it is required. are provided with a means sultable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 19.3.6.3 are permitted. Roller latches are prohibited by CMS regulations Roder latones will be removed in all health care facilities. off all doors and replaced with holls, locks and standard door latch At Roller latches will no lenger be used on facility dears. AN finding Will be taking This STANDARD is not met as evidenced by: The corridor doors to resident in DON Based on observation on Tuesday, October 4, 2011 between 9:30 AM and 1:00 PM the following rooms 104, 119-13, 127 and 12,3 will now close, latch, 1) The corridor doors to resident rooms 106, 119B, 127 and 123 did not close latch and seal. and seal. 42 CFR 483.70(a) Doors will be cheeked perializing K 027 K 027 NFPA 101 LIFE SAFETY CODE STANDARD so insure proper closing, latching and sealing for resident backers. SS≠D Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1%-inch thick solld bonded wood core. Non-rated Fridings with by follow to protective plates that do not exceed 48 inches PI COMMITTEL MUNTAGY X 3. from the bottom of the door are permitted.) ABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE 10-21-11 RN KNHA WCL

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/10/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION O1 - MAIN BUILDING 01	COMPLET	
		345124	B. Wil	1G		10/04	1/2011
	ROVIDER OR SUPPLIER SE HEALTHCARE OF	ELKIN		56	EET ADDRESS, CITY, STATE, ZIP CODE 30 JOHNSON RIDGE RD LKIN, NC 28621		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
K 027	Horizontal sliding of Doors are self-clost accordance with 19 not required to swi	age 1 doors comply with 7,2.1.14, sing or automatic closing in 9,2.2.2.6. Swinging doors are ng with egress and positive tired. 19.3.7.5, 19.3.7.6,	Kı	027	•		
Қ 029 ՏS≃l [∓]	Based on observa 2011 between 9:30 was noted: 1) The cross corrid to resident room 1 42 CFR 483.70(a) NFPA 101 LIFE So One hour fire rated fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro the approved auto option is used, the other spaces by st doors. Doors are field-applied protect	is not met as evidenced by: ation on Tuesday, October 4, DAM and 1:00 PM the following for smoke doors located next 30 did not close smoke tight. AFETY CODE STANDARD It construction (with ¾ hour or an approved automatic fire em in accordance with 8.4.1 betects hazardous areas. When matic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or cive plates that do not exceed be bottom of the door are 2.1	ĸ	029	Astrical strip has be added to the cross is comple doors located to resident room 130 you close smeke tight astrical strip will be All findings will be to PI committee me.	dogist remain	
	Based on observe 2011 between 9:3 was noted:	is not met as evidenced by: ation on Tuesday, October 4, 0 AM and 1:00 PM the following I storage closet located at both			The oxygen and Store Closets theodox A & B I A Closets to the A & B I A Closets and include:	ye sem sw has when	10 311

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345124	B. WING		10/04/2011
	ROVIDER OR SUPPLIER GE HEALTHCARE OF	ELKIN		REET ADDRESS, CITY, STATE, ZIP CODE 560 JOHNSON RIDGE RD ELKIN, NG 28621	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
K 029	and latching hardwa	B did not have a self-closure are.	K 029	And a harmen	wed for stage, tent with proper to the party with the whiteh