

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

Accepted per D.U.
MAY 22 2012

PRINTED: 05/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345150	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2012
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NAME OF PROVIDER OR SUPPLIER KENANSVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BEASLEY STREET KENANSVILLE, NC 28349
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and family and staff interviews, the facility failed to ensure 1 of 18 sampled residents, Resident # 12, was dressed in personal clothing.</p> <p>Findings included:</p> <p>Review of the clinical record for Resident #12 indicated the resident was admitted to the facility on 12/15/2006. Her cumulative diagnoses included Huntington's Chorea.</p> <p>Record review of the resident's Minimum Data Set (MDS) dated 10/11/2011 indicated the resident had severe cognitive impairment and was totally dependent on staff for all activities of daily living.</p> <p>The resident's care plan dated 10/11/2011 indicated the resident required total care for all activities of daily living.</p> <p>The resident was observed on 04/30/2012 at 2:00 PM in her room, awake and lying on her bed. She did not respond to questions. She was not observed to be contracted or stiff. She was dressed in an institutional gown.</p>	F 241	<p>F241</p> <p>Resident # 12 was re-dressed in personal clothing on 5-3-12. Resident care plan was updated to reflect change on 5-3-12.</p> <p>The Staff Development Coordinator will provide re- education to the Facility current Licensed and non-licensed nursing staff on providing dignity and respect in full recognition of his or her individuality, to include choices regarding dressing in personal clothing when out of bed by 5-31-12.</p> <p>The DON or designee will complete interview with resident or responsible party to identify resident preference regarding clothing when out of bed by 5-31-12.</p> <p>The facility Director of Nursing will complete 1-2 random audit each unit Monday – Friday times four weeks, bi-monthly times to ensure residents are properly dressed in personal clothing, or according to-plan of care.</p> <p>The Director of Nursing will review results of random audits weekly times four and bi- monthly times one, monthly thereafter. Any trends or negative finding will be reported to QA&A committee</p>	5-31-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5-18-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>In an interview with Resident #12's family member on 05/01/2012 at 12:17 PM, the resident's family member voiced concern the resident was never dressed in her own clothing. The family member indicated the resident had a closet full of her own clothing. The family member also reported they had mentioned this concern on several occasions to various facility staff and was told there was not enough staff to dress the resident daily. The family member did not give specific names. The family member further reported they did not file a written grievance.</p> <p>The resident was observed on 05/01/2012 at 3:29 PM in her room, lying on her bed. She was dressed in an institutional gown.</p> <p>The resident was observed on 05/02/2012 at 12:45 PM in the front lobby of the building. She was seated in a geriatric chair and was dressed in an institutional gown.</p> <p>In an interview with Resident Care Specialist #1 (RCS) on 05/02/2012 at 2:05 PM, the RCS reported she worked on the hall where Resident #12 resided and worked with the resident often. The RCS opened the closet door, and it was full of the resident's personal clothing. When asked if the resident wore her own clothing, the RCS reported they did not put her own clothes on her because she was difficult to dress and they also did not want to take a chance messing up the dressing around the gastrointestinal tube.</p> <p>The Director of Nursing (DON) was interviewed on 05/02/2012 at 3:45 PM. When asked why Resident #12 was not dressed in her own</p>	F 241		5-31-12

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F 241	Continued From page 2 clothing, she reported the resident was stiff and difficult to dress. The DON indicated she had no knowledge of any concerns from the resident's family related to the resident not being dressed in her own clothing.	F 241	F246 Resident #12 was dressed and out of bed on 5-2-12. The current facility residents and or responsible parties will be interviewed to identify resident preferences regarding facility schedule for out of bed starting 5-18-12 and every ninety days. Each resident care plan will be reviewed and updated to reflect resident preference regarding out bed schedule.	5-31-12	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review and family and staff interviews, the facility failed to ensure enough geriatric chairs to allow 1 of 9 residents (Resident #12) to be out of bed when scheduled. Findings included: Review of the clinical record for Resident #12 indicated the resident was admitted to the facility on 12/15/2006. Her cumulative diagnoses included Huntington's Chorea. Record review of the resident's Minimum Data Set (MDS) dated 10/11/2011 indicated the resident had severe cognitive impairment and was totally dependent on staff for all activities of daily living. The resident's care plan dated 10/11/2011	F 246	Each resident will be assessed by the Rehab department to ensure that each resident current seating devices is appropriated starting 5-3-12 and ongoing times ninety days. Facility Director of Nursing completed facility assessment of current inventory of Geri Chair on 5-4-12. The facility Director of Nursing will complete 1-2 random audits Monday through Friday on each unit weekly times four, bi- monthly times one, and monthly thereafter, to ensure that residents are up and out of bed per facility schedule and preference. The Director of Nursing will review results of random audits weekly times four and bi- monthly times one, and monthly thereafter. Any trends or negative finding will be reported to the QA&A committee		

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F 246	<p>Continued From page 3</p> <p>indicated the resident required total care for all activities of daily living.</p> <p>Review of the resident's transfer report for the month of April 2012 revealed the resident was transferred out of bed on 04/02/2012, 04/04/2012, 04/09/2012 and 04/11/2012. The care tracker indicated the activity did not occur on the remaining days.</p> <p>Review of April 2012 nursing notes revealed no documentation which indicated the resident needed to remain in bed.</p> <p>The resident was observed on 04/30/2012 at 2:00 PM in her room, awake and lying on her bed. She did not respond to questions.</p> <p>In an interview with Resident #12 's family member on 05/01/2012 at 12:17 PM, the resident's family member voiced concern the resident was rarely gotten up out of bed and indicated they felt this was unhealthy for the resident. The family member also reported they mentioned this concern on several occasions to various facility staff and was told there was not enough staff to get the resident up more often. The family member gave no staff names. The family member reported they did not file a written grievance with the facility.</p> <p>The resident was observed on 05/01/2012 at 3:29 PM in her room. She was awake and lying on her bed.</p> <p>The resident was observed on 05/02/2012 at 12:45 PM. She was seated in a geriatric chair in the facility lobby.</p>	F 246			

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F 246	Continued From page 4 In an interview with Resident Care Specialist #1 (RCS) on 05/02/2012 at 2:05 PM, the RCS reported she worked on the hall where Resident #12 resided and worked with the resident often. The RCS reported residents were scheduled to be out of bed 3 days a week. She indicated Resident #12 was scheduled to be gotten out of bed on Monday, Wednesday and Friday. She further reported there was not always enough staff on duty to get residents up as scheduled. In an interview with the Assistant Director of Nursing on Cathy Johnson 05/02/2012 at 3:40 PM, she reported the facility used a care tracker for each resident. The ADON indicated if a resident did not get up on any specific day, the care tracker indicated "activity did not occur." The Director of Nursing (DON) was interviewed on 05/02/2012 at 3:45 PM. The DON reported residents had scheduled days when to be out of bed. She indicated it was her expectation residents be gotten out of bed on scheduled days unless contraindicated. The DON further reported the facility did not have enough geriatric chairs in the facility to get all the residents up as scheduled. The DON indicated she had no knowledge of any family members of resident #12 voicing concerns the resident was not being gotten out of bed. In an interview with the DON on 05/03/2012 at 10:00 AM, she indicated the facility had a total of 8 working geriatric chairs and a total of 23 residents who required geriatric chairs. She indicated the facility recently put in a work order for more chairs and was also borrowing geriatric	F 246		

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F 246	Continued From page 5 chairs from another facility.	F 246			

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V-protected construction, one story, with a complete automatic sprinkler system.</p> <p>The deficiencies determined during the survey are as follows:</p> <p>K 018 SS=D NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by:</p>	K 000	<p>K018 Correction for the alleged non compliant finding noted as resident bedroom (106) door did not close and latch for a smoke tight seal was to adjust door as needed to ensure a reliable smoke tight latch and seal. The Maintenance Director will survey the remainder of the building for any like instances and repair upon discovery. Door checks will continue weekly for the next four weeks with results presented to and discussed at the monthly Safety Committee meeting, then continue with monthly door checks reported as scheduled quarterly until next annual survey. Completion date of 06/18/2012</p> <p>K062 Correction for the alleged noncompliant finding noted as orifice on sprinkler head in Social Work office was painted, will be to replace the affected sprinkler head. The Maintenance Director will survey the remainder of the building to identify any other affected heads and schedule replacements if needed. These checks will continue monthly for the next three months with all results reported to and discussed at those monthly Safety Committee meetings, then continue quarterly thereafter until next annual survey. Completion date of 06/22/2012</p>	6-22-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 6-15-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's policies and 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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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: resident bedroom(106) door did not close and latch for smoke tight seal. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: orifice on sprinkler head located in Social worker's office was painted at time of survey. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 018	K144 Correction for the alleged noncompliant finding noted as the generator failed to crank and transfer within 10 seconds, is to have the generator checked and adjusted by contractor to ensure transfer time within state guidelines. The generator will be monitored during regular weekly testing for proper crank and transfer time for the next four weeks with those results documented and reported to the monthly Safety Committee meeting. A summary of regular weekly test time documentation will then continue to be reported at scheduled quarterly Safety Committee meetings until next annual survey. Completion date of 06/18/2012	6-22-12
K 062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		
K 144 SS=E	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: generator failed to crank and transfer within 10 seconds on test. 42 CFR 483.70(a)	K 144		