

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

Received 5/29/13
acceptance
in place

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2013
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interviews, the facility failed to provide privacy while bathing two residents (#1 and #3) at the same time. Findings include:</p>	F 164	<p><u>Corrective Action for Identified Resident(s):</u> NA # 1, Nurse #1, and Nurse #2 were all given 1 on 1 training re: each resident's right to personal privacy and their personal obligation to ensure said right is respected and observed.</p> <p><u>Identification of Residents at Risk Due to Deficient Practice:</u> All residents have the potential to have their personal privacy violated. Resident #1 and #3 had no negative outcome.</p> <p><u>Corrective Action/Systemic Change Plan:</u> All nursing staff was given in-service training re: each resident's right to personal privacy and their personal obligation to ensure said right is respected and observed.</p> <p><u>Monitoring</u> A member of the nursing management team will audit Resident bathing on the following schedule. 20% of all resident baths will be audited weekly X 3 weeks, then monthly</p>	6/3/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Wade Koz...

TITLE

Executive Director 5/28/13

(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.

X

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F 164	<p>Continued From page 1</p> <p>1. Resident #1 was admitted to the facility on 3/15/2011, and readmitted on 12/18/2012 with multiple diagnoses including dementia and depression.</p> <p>The quarterly Minimum Data Set (MDS), dated 4/10/2013 noted that Resident #1 was severely impaired for cognition and daily decision making, and that Resident #1 needed extensive or total assistance of one to two persons for all activities of daily living (ADLs). Resident #1 was totally dependent on the physical assistance of one staff for bathing.</p> <p>A review of incident/accident reports revealed that on 4/25/2013, Resident #1 was receiving a shower with the assistance of nurse assistant (NA) #1. The incident report stated that NA#1 called Nurse #1 to the shower room, where Resident #1 was sitting in a shower chair.</p> <p>In an interview on 5/6/2013 at 12:35 PM, NA #1 stated that she had turned to get a towel when Resident #1 stood up and started to fall. NA #1 stated that she grabbed the resident to keep her from falling, but the resident hit her head on the wall of the shower. NA #1 stated that she lowered Resident #1 onto the shower chair and called Nurse #1 on the walkie-talkie. NA #1 stated that both Nurse #1 and Nurse #2 came into the shower/spa room and assessed Resident #1 and helped get her dressed and into her wheel chair. Another NA took Resident #1 out and NA#1 proceeded to take care of Resident #3. NA #1 stated that the next day the Assistant Director of Nursing (ADON) called her into the office and told her that she could not have two people in the</p>	F 164	X 3 months, then quarterly as a part of the routine QA program. The DON/ADON will review all audits. Any deficient practice by nursing staff will be addressed thru training/retraining of staff member, with discipline applied as appropriate for repeat offenders.		

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F 164	Continued From page 2 shower room with one NA. NA #1 stated that she told the ADON that NAs did that all the time. 2. Resident #3 was admitted 12/17/2007 with multiple diagnoses including dementia, and depression The quarterly Minimum Data Set (MDS) dated 2/25/2013 noted the resident was severely impaired for cognition, needed limited to extensive assistance of one to two persons for all activities of daily living (ADLs). Resident #3 was totally dependent on the physical assistance of one staff for bathing. In an interview on 5/6/2013 at 12:35 PM, NA #1 stated that she had turned to get a towel when Resident #1 stood up and started to fall. NA #1 stated that she grabbed the resident to keep her from falling, but the resident hit her head on the wall of the shower. NA #1 stated that she lowered Resident #1 onto the shower chair and called Nurse #1 on the walkie-talkie. NA #1 stated that both Nurse #1 and Nurse #2 came into the shower/spa room and assessed Resident #1 and helped get her dressed and into her wheel chair. Another NA took Resident #1 out and NA#1 proceeded to take care of Resident #3. NA #1 stated that the next day the Assistant Director of Nursing (ADON) called her into the office and told her that she could not have two people in the shower room with one NA. NA #1 stated that she told the ADON that NAs did that all the time.	F 164			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	<u>Corrective Action for Identified Resident(s):</u> The nurse on duty assessed and treated Resident #1 immediately.	6/3/13	

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F 323	Continued From page 3 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to provide supervision that prevented a resident from falling out of a shower chair, during a shower for one of three residents sampled (Res. #1). Findings include: Resident #1 was admitted to the facility on 3/15/2011, and readmitted on 12/18/2012 with diagnoses of dementia, depression, anemia, degenerative joint disease, and a history of falls. The quarterly Minimum Data Set (MDS), dated 4/10/2013 noted that Resident #1 was severely impaired for cognition and daily decision making, and that Resident #1 was extensive or total assist for all activities of daily living (ADLs), with one to two person physical assist. Resident #1 was total dependence for bathing with one person physical assist. The MDS also noted that for moving from a seated to a standing position, and surface to surface transfer, Resident #1 was not steady, and was only able to stabilize with staff assistance. From the MDS, the Care Area Assessment (CAA) signaled as significant areas, falls and cognitive loss. These areas were care planned on 2/4/2013. Care plan approaches were to provide hands on assist as needed for all ADLs, provide a clutter free environment, provide supervision and ample time to complete ADL tasks. The care plans were updated on 4/11/2013.	F 323	<u>Identification of Residents at Risk Due to Deficient Practice:</u> All residents have the potential to be affected. <u>Corrective Action/Systemic Change Plan:</u> All nursing staff involved in bathing of residents was given in-service training re: the importance of proper preparation for bathing to ensure all needed items are close at hand and that bathing is to be a 1 on 1 process between the resident and the staff member only. <u>Monitoring:</u> A member of the nursing management team will audit Resident bathing on the following schedule. 20% of all resident baths will be audited weekly X 3 weeks, then monthly X 3 months, then quarterly as a part of the routine QA program. The DON/ADON will review all audits. Any deficient practice by the nursing staff will be addressed thru training/retraining of staff member, with discipline applied as appropriate for repeat offenders.		

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F 323	<p>Continued From page 4</p> <p>A review of incident/accident reports revealed that on 4/25/2013, Resident #1 sustained an abrasion and bruising to her forehead while in the shower/spa room on the 200 hall. The incident report stated that NA#1 called Nurse #1 to the shower room, where Resident #1 was sitting in shower chair, floor was free of clutter, shower floor was wet. Nurse #1 observed bruising and abrasion to left area of forehead. Vital signs were taken and were within normal limits (WNL). The root cause was listed as NA turned to get towel. The plan was to " add a towel bar so towel will closer for staff. " The DON and Administrator had signed the incident/accident report.</p> <p>On 5/6/2013 at 12:35 PM, in an interview, NA #1 stated she had worked in the facility for 5 years. NA #1 stated that she had turned to get a towel when Resident #1 stood up and started to fall. NA #1 stated that she grabbed the resident to keep her from falling, but the resident hit her head on the wall of the shower. NA #1 stated that she lowered Resident #1 onto the shower chair and called Nurse #1 on the walkie-talkie. NA #1 stated that both Nurse #1 and Nurse #2 came into the shower/spa room and assessed Resident #1 and helped get her dressed and into her wheel chair. Another NA took Resident #1 out and NA#1 proceeded to take care of Resident #3. NA #1 stated that the next day the Assistant Director of Nursing (ADON) called her into the office and told her that she could not have two people in the shower room with one NA. NA #1 stated that she told the ADON that NAs did that all the time, and the ADON told her that he would have a meeting with the NAs to tell them that NAs could not do that, and that he would put something on the bulletin board.</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>On 5/6/2013 at 12:55 PM, in an interview, NA#2 stated that she had worked at the facility for 2 years, mostly works with the male residents, and never takes two residents into the shower room at one time. NA #2 stated that she usually works in the afternoons. She stated that there had not been a meeting recently that she knew of, but that it was understood that you do not take two residents into the shower room at one time. An observation was made of the employee bulletin boards. There was no information in regard to NAs showering/bathing residents.</p> <p>On 5/6/2013 at 1:05 PM, in an interview, Nurse #1 stated that she was called to the shower room where Resident #1 had hit her head. Nurse #1 stated that Nurse#2 was with her, and that they both noted the reddened area on Resident #1 's forehead. Nurse #1 stated that Resident #1 was sitting in the shower chair. Nurse#1 stated that a cold compress was applied, the physician was called for an order to send Resident #1 to the hospital for evaluation, and the RP was called to let her know. Nurse #1 stated that she had worked at the facility for 2 ½ years. Nurse#1 stated that she had known other NAs to give baths to two residents at one time, and that she had never done that.</p> <p>On 5/6/2013 at 1:30 PM the ADON stated that he</p>	F 323		
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F 323	Continued From page 6 did not have an inservice meeting, but went to each NA and told them personally that they could only have one resident at a time to be bathed in the shower room, and had them sign the inservice sheet. The ADON stated that the inservice is ongoing, and plans to go to all of the nurses. The inservice sheet was reviewed. On 5/7/2013 at 8:30AM, NA#1 demonstrated how she had tured to get a towel off of the counter to dry Resident #1 when Resident #1 stood up and started to fall. There was a towel bar beside the entrance to the shower, but the shower curtain was tucked into it, so that it would not accommodate a towel. On 5/7/2013 at 8:45AM, in the shower/spa room, NA#4 stated that she placed her supplies on the counter because the shower curtain was tucked into the towel bar. She stated that she wished there was a tie back for the shower curtain like the one for the whirlpool tub. NA#4 stated that the towel bar has always been there. On 5/7/2013 at 11:30AM, an observation was made of the 200 hall shower/spa room and no new towel bar was noted.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	<u>Corrective Action for Identified Residents:</u> The nurses involved, Nurse #6 and Nurse #1 were immediately in-serviced one on one re: the importance of keeping all medications secure and maintaining the privacy of all Resident personal information at all times.	6/3/13	

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F 431	<p>Continued From page 7</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and staff interviews, the facility failed to maintain a locked medication cart for two of two carts. Findings include: 1. On 5/6/13 at 4:37 PM, the medication cart on Hall 4 was observed to be unattended and unlocked with a ring of keys on top of the cart, and the Medication Administration Record (MAR) open and without a cover. Continuous observation was made of the cart until Nurse #6</p>	F 431	<p>Identification of Residents at Risk Due to Deficient Practice: All Residents have the potential to be affected.</p> <p>Corrective Action/Systemic Change Plan: All Residents have the potential to be affected. Therefore all Nurses were in-serviced on their responsibility to keep all medications secure at all times and to maintain each Residents right to privacy at all times.</p> <p>Monitoring: The DON or designee will check each medication cart on each shift every day for 2 weeks to ensure that the medications are secure and that Resident's personal information is protected. The audits will then be performed 2 X per week for 2 weeks, and then once per week X 4 weeks, and then quarterly as a part of the routine QA program. Any deficient practice discovered thru the audits will be addressed thru training/retraining of staff members with discipline applied as appropriate for repeat offenders.</p>		

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F 431	<p>Continued From page 8</p> <p>approached the cart at 4:46 PM. The nurse was observed to look at the MAR, and open the cart drawer and withdraw a resident 's medication. The keys remained on top of the cart. The nurse stated that she would be finished with her medication pass at 11 PM that evening.</p> <p>In an interview on 5/6/13 at 4:49 PM, the Director of Nursing (DON) stated that it was her expectation that if a nurse leaves the medication cart, the cart should be locked, the MAR closed or covered, and that the nurse would take the keys to the cart.</p> <p>In an interview on 5/7/13 at 10:40 AM, Nurse #7 stated that if she had to leave the medication cart for any reason, she would lock the cart, take the keys, make sure there were no medications left on top of the cart, and close the MAR.</p> <p>On 5/7/13 at 10:50 AM, in an interview, Nurse #6 stated that she had been a nurse for a long time and knew that she had made a mistake by leaving the medication cart open and unattended. The nurse stated that she had been having some health problems and " just had to walk away from the cart. " Nurse #6 stated that she knew she should have locked the cart, taken the keys, and closed the MAR.</p> <p>2. On 5/7/13 at 9:15 AM, Nurse #1 was at the medication cart, which was at the door of a room on the 100 Hall. Nurse #1 went into the room and closed the door, and the cart was observed to be unlocked. Two NAs walked by the cart. Nurse #1 came out of the room, disposed of objects into the sharps container, removed her gloves, locked the cart, and reentered the room.</p>	F 431			

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