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	345437	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS CASHIERS HOSPITAL IN	190 HOSPITAL DRIVE HIGHLANDS, NC 28741

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain 1 of 8 residents who were fed in the restorative dining room in a position to prevent possible aspiration. (Resident #27). The findings included: Resident #27 was admitted to the facility on 07/01/10. She was hospitalized on 01/11/13 for pneumonia. Resident #27 had been discharged from Physical Therapy on 01/11/13. Therapy progress notes dated 01/12/13, noted that Resident #27 sat through 3 sessions for alignment in her wheelchair with her neck, head, and pelvis at center midline with adaptive positioning devices to increase participation in out of bed activities. At time of discharge, Physical Therapy stated the resident was successfully and appropriately positioned in a wheelchair with adaptive devices for midline spine and cervical. The notes stated registered nursing staff were educated on proper outfitting of this resident in her wheelchair. Remaining impairments included cognition,	F 309	Highlands Cashiers Hospital, Inc. response to this report of survey does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law. " F 309 Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: The resident has been evaluated and treated by Occupational Therapy for proper modalities to ensure proper alignment during meals. A neck cradle has been added to her wheel chair to provide neck support and keep the head at midline and in a neutral position. The current modalities have been added to the resident care plan and to the Caretracker meal documentation personalization area. Staff have been trained on the use of her new specific requirements in addition to the older recommendations of small bites	4/22/14

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

Electronically Signed | 04/22/2014

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decreased strength and balance, decreased posture and motor control and decreased trunk control. Other than a new wheelchair, the report did not state any specific devices to be used while Resident #27 was in the wheelchair.

On 01/22/13 Resident #27 was readmitted to the facility with the diagnoses including mental retardation, a history of pneumonia and congenital heart disease.

A Speech Therapy screening report dated 01/23/13 stated this screen was for a re-admission for status post pneumonia. The screening stated Resident #27 had a long standing diagnoses of oropharyngeal dysphagia with multiple hospitalizations for aspiration pneumonia and that she was on the lease restrictive diet being pureed with honey thick liquids.

Nursing notes dated 11/14/13 at 6:50 PM stated the nurse brought Resident #27 back from the dining room at 5:30 PM relaying she had 3 bites of food and a drink and had "aspirated." She did not need to be suctioned.

Nursing notes dated 12/14/13 at 12:10 PM stated that this morning at breakfast, Resident #27 "Possibly aspirated." Resident was brought back to the hall and suctioned twice.

Nursing notes dated 12/15/13 (7 PM - 7 AM) stated it was reported by off going nurse that Resident #27 "again possibly aspirated" at supper.

Nursing notes dated 12/18/13 noted Resident #27 continued to eat pureed foods with honey thick and sips between bites.

How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.
All resident charts were reviewed with the therapy team for the purpose of identifying existing recommendations and ensuring recommendations were carried out on the care plan and Caretracker. No additional deficient practices were noted.

Systemic changes to ensure the deficient practice will not occur:
Therapy staff have been educated and will include any new equipment needs, instructions, or interventions on the discharge summary. Each area will be filled in, even if it is filled in with no recommendation to ensure that nursing is aware that no new interventions were recommended. The discharge summary will be given to the Unit Coordinator for filing in the chart, the MDS Nurse for care planning, the Restorative Nurse for Caretracker update and messaging, and the DON for quality monitoring. The staff has been educated on the importance of reading Caretracker kiosk messages for resident updates and looking on the meal intake recording screen for patient specific instructions. New employees will be educated on communication of resident interventions in New Employee Orientation.
The staff have been educated on the proper positioning of residents at meal times and during nutritional intake.

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F 309	Continued From page 2 liquids. Resident needed head elevated to 90 degrees and assist to tuck chin as best as possible with intake. The resident tended to hold her head back increasing the risk of aspiration. The most recent Minimum Data Set, an annual dated 01/27/14, coded her with long and short term memory deficits, severely impaired decision making skills, requiring extensive assistance with eating and receiving a mechanically altered diet. She was not checked as having signs or symptoms of a possible swallowing disorder. A Care Plan was developed 01/28/14 for being at risk for aspiration related to difficulty swallowing. The interventions to meet the goals for Resident #27 to not have any aspiration episodes included: diet and fluids as ordered; allow resident time to eat and drink; document and report any aspiration symptoms to nurse/MD (doctor); sit resident upright for at least 30 minutes after meals; and restorative dining if indicated. Nursing notes dated 02/19/14 at 3:35 PM stated Resident #27 "got choked on puree lunch today, brought back to hall, required suctioning". Observations made over two meals revealed the following positioning of Resident #27: *On 03/31/14 at 12:26 PM, Resident #27 had her neck roll moved to behind her back. During the entire meal, Resident #27's neck was hyperextended, causing her to be fed the pureed food and honey thickened milk while looking towards the ceiling. *On 04/02/14 at 8:47 AM, Resident #27 was observed during the breakfast meal. She was seated with 3 other residents at a moon shaped table. NA #1 would feed one resident then go	F 309	CNA□s have been educated on the proper communicating of concerns with any type of positioning to the floor nurse. Floor nurses have been educated on the proper procedure of documentation and referral to therapy for evaluation of positioning concerns. New employees will be educated on proper ways to initiate therapy intervention in New Employee Orientation. How facility plans to implement the corrective action and evaluate for it□s effectiveness: All therapy discharge summaries will be audited within 1 week of discharge to ensure modalities have been added to the care plan, added to care tracker, and are currently being utilized by staff. Audits will be conducted weekly for 4 months by the DON. Audits are reviewed by the QAPI Committee. The QAPI Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.	

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around the table and give each of the other residents a bite of food or drink of liquid. Although there was a neck roll in place, Resident #27's neck was hyperextended causing her to look at the ceiling while Nurse Aide (NA) #1 fed her the pureed food and honey thickened milk. At 8:50 AM after NA #1 fed Resident #27 a spoon full of honey thickened milk, NA #1 told the resident to swallow. NA #1 continued to feed Resident #27 with the resident's neck hyperextended with no verbal cues to swallow or look down tor forward through 8:57 AM. At 8:59 AM the nurse aide fed her a large spoon of eggs. At 9:00 AM the resident was fed a large spoon of meat, followed by 2 more bites of pureed food. Her next bite at 9:05 AM was a bite of egg, followed by a bite of meat and a spoon of milk. Resident #27 remained looking up at the ceiling, with her neck hyperextended and at no time did the nurse aide give cues for head position or cues about swallowing. At 9:07 AM, Resident #27 began coughing. At 9:08 AM, when she continued to cough, NA #1 got up and went to the resident's side and held her head forward so that her eyes were now straight ahead and her face forward. Resident #27 continued to cough as the nurse aide held her head straight forward. At 9:10 AM, NA #1 returned to her seat at which time, Resident #27's neck returned to the hyperextended position. She coughed one more time and at 9:11 AM, staff gave the resident a spoon of milk. At 9:12 AM, the resident coughed again. The NA did not cue the resident to lift her head or swallow. NA #1 continued to feed Resident #27 for the remainder of the meal with the resident's neck hyperextended. She was noted to cough again at 9:31 AM while being fed desert with her neck hyperextended.

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On 04/02/14 at 9:37 AM, NA #1 was asked about Resident #27's position at meals. NA #1 stated in the past she had been given a neck pillow due to her hyperextension her neck. NA #1 stated she gave this resident small bites and made sure she swallowed between bites. She stated that sometimes she held her head forward/straight. She was unaware of any special instructions or devices to assist with head positioning except for the neck pillow.

On 04/02/14 at 1:42 PM, Nurse #2 (the restorative nurse) stated Resident #27 was not in a restorative program at the present time. She stated there was no specific method used to feed Resident #27 except for small bites and alternating food and fluids as she could tolerate. Over the past year, Nurse #2 stated Resident #27 seemed to be more comfortable with her head back, looking upward. She further stated that the resident was referred to therapy several times for positioning and staff never got feed back about any positioning device other than a special wheelchair for her.

On 04/02/14 at 2:07 PM, an interview was conducted with the Rehabilitation Manager (RM). RM stated she was unaware of any issues with Resident #27 having an extended neck. She was last seen in therapy to assist with sitting straight in a wheelchair. When asked about the treatment note related to devices in use for cervical extension on the therapy form dated 01/12/13, RM stated upon discharge she was positioned in a way "we consider neutral." She explained further that that would mean facing forward. She further added that she thought a rolled up towel was added for cervical support. RM stated that the resident should not be fed while her neck was

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F 309	Continued From page 5 hyperextended. Per the RM, she has not seen Resident #27 eat in a while and no one had mentioned concerns with the resident's position during meals. Interview with the Director of Nursing (DON) on 04/03/14 at 11:24 AM, revealed that she expected the discharge summary to explain what intervention, if any, was needed. She stated there was no specific device for her neck mentioned on the discharge summary of 01/12/13. Interview with the Speech Therapist (ST) who saw Resident #27 on 01/23/13 revealed that, at that time, Resident #27 needed cues to hold her head upright and straight which she deemed was due to fatigue and weakness. ST no longer worked in this facility. The Physical Therapist who wrote the note which referred to adaptive devices in the discharge summary dated 01/12/13, no longer worked for the facility and the facility was unable to provide a phone number to contact her.	F 309		
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 prevent accidents. This REQUIREMENT is not met as evidenced	F 323		4/22/14

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F 323	Continued From page 6 by: Based on observations, staff interviews and review of the Material Safety Data Sheet, the facility failed to safely handle a portable oxygen cylinder when replacing 1 of 1 sampled resident's empty oxygen cylinder. (Resident #22). The findings included: The Material Safety Data Sheet (MSDS) related to oxygen provided by the facility was reviewed. "Section 7. Handling and storage" included instructions to "Use a suitable hand truck for cylinder movement." On 04/01/14 at 2:09 PM, Resident #22 was observed using oxygen at 2.5 liters per minute via a nasal cannula. On 04/02/14 at 8:27 AM, Nurse #1 was observed assisting Resident #22 from a recliner into a wheelchair. When staff went to change Resident #22's oxygen from the oxygen concentrator to the portable oxygen cylinder located on the back of her wheelchair, Nurse #1 noticed the portable oxygen cylinder was empty. Nurse #1 proceeded to hand carry the empty oxygen cylinder, by the gauge, down a hall and a half to where the full cylinders were stored. Nurse #1 retrieved a full oxygen cylinder and proceeded to hand carry the full oxygen cylinder back down the hall and a half by the gauge to the resident. Nurse #1 then proceeded to connect the resident's nasal cannula to the new full oxygen cylinder which she had placed on the back of her wheelchair. During an interview with Nurse #1 on 04/02/14 at 12:01 PM, the nurse stated she normally carried the oxygen cylinders by the gauge or under her arm as they were light weight. Nurse #1 further	F 323	" F 323 Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: An audit was conducted and no residents were found to be affected by the deficient practice. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. A sign has been posted on the oxygen storage chest stating You must use a hand cart to transport oxygen cylinders, full or empty. Hand carts have been placed next to the storage chest for easy access. Systemic changes to ensure the deficient practice will not occur: All nursing staff has been instructed on the importance of proper oxygen transport and handling. New employees will be educated on proper oxygen transport and handling in New Employee Orientation. How facility plans to implement the corrective action and evaluate for it□s effectiveness: The Charge Nurse is responsible for visibly monitoring and documenting the proper transport and handling of oxygen cylinders by residents and staff a minimum of 8 times weekly (due to low usage and low patient volume) for the next 4 months. Audits are reviewed by the	

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F 323	Continued From page 7 stated the facility had rolling carriers for the oxygen cylinders, however, once you used the carrier and replaced the new oxygen on the back of a wheelchair, the carrier wasn't needed anymore and would have to be returned to storage. She also stated that sometimes, the resident would be transported in the wheelchair down to the location of the oxygen cylinders and the change would take place there. Interview with the Director of Nursing on 04/02/14 at 4:00 PM revealed the staff should never leave a oxygen cylinder standing unsecured, however, she was not aware that oxygen cylinders could not be hand carried.	F 323	QAPI Committee. The QAPI Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide an alternative intervention to address a protein deficit for 1 of 3 sampled residents reviewed for nutrition, who refused the original intervention of liquid protein. (Resident	F 325	" F 0325 Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice:	4/22/14

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F 325	Continued From page 8 #22). The findings included: Resident #22 was admitted to the facility on 01/21/14 with diagnoses including atrial fibrillation, chronic venous stasis, chronic hypoxemic respiratory failure, and chronic anticoagulation for pulmonary embolism. The admission physician orders dated 01/21/14 included a regular diet with no added salt. The Nutritional History dated 01/28/14 included the Registered Dietician's (RD) assessment which stated Resident #22's intake was fair to good with her intake varying from meal to meal. The note continued to state the nutritional status was "poor" with her albumin level being low at 2.3 milliequivalent/liter (meq/L) (normal range 3.4 -5.0 meq/L), her total protein level being low at 5.8 gram/deciliter (G/DL) (normal range 6.4 - 8.2 G/DL) and her calcium level being low at 8.3 milligram/deciliter (MG/DL) (normal range being 8.5 - 10.1 MG/DL). The note stated "Will order Healthy shot (a liquid protein supplement) daily to improve nutri. (nutrition) status." The Minimum Data Set, the admission dated 01/28/14, coded Resident #22 as being cognitively intact, having no behaviors, requiring supervision with eating, and having no swallowing or chewing issues. The Care Area Assessment dated 02/03/13 for nutrition stated the resident was not currently at nutritional risk and no care care plan would be developed but monitoring would occur. There was no nutritional care plan found in the medical record.	F 325	A powdered protein supplement was ordered for the resident on 3/30/2014. She has since refused it and it was discontinued per the physicians order. The resident is now receiving double portions of lean protein at meals. Her protein and albumin levels are to be rechecked in 3 months. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. All residents with a CMP or protein and albumin level ordered in the last 6 months have been reviewed for the implementation, compliance, and modification of recommended nutritional supplements or the need to initiate supplements if indicated. No additional deficient practices were noted. Systemic changes to ensure the deficient practice will not occur: All nursing staff received training on the proper documentation and discontinuation of orders for nutritional supplements. All nursing staff received training on the proper notification of the Physician, Dietician, Dietetic Technician, and Weight and Wounds Committee members of refused or discontinued nutritional supplements. New employees will be educated on proper chemical use and storage in New Employee Orientation. The Registered Dietician will place a copy of her assessment and recommendation in the MDS Coordinator□s, Wound Care Nurse, and Dietetic Technician□s mail	

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F 325	Continued From page 9 A physician's telephone order was written by the RD on 02/06/14 for the Healthy Shot one time per day for low albumin. Review of the February Medication Administration Record (MAR) revealed Resident #22 refused the Healthy Shot every day from 02/07/14 through 02/13/14. The MAR noted via a hand note that this order was discontinued due to refusal. There was no physician's order or nursing note indicating that the physician and RD were notified of the refusal. On 04/02/14 at 10:53 AM the Dietetic Technician (DT) stated that Resident #22 was above her ideal body weight but was nutritionally at risk due to her low protein and that was dealt with by providing the Healthy Shot. Upon further interview on 04/02/14 at 11:44 AM, DT stated that he was unaware she had refused the Healthy Shot since it's initiation. He was not sure there was a system to alert the dietary department that an intervention such as the Healthy Shot was discontinued. He stated the RD came to the facility 2 - 3 times per week. He also stated he was not sure when the next laboratory test for albumin would be obtained for Resident #22. On 04/02/14 at 11:11 AM Nurse #3 stated she could not locate a physician's order discontinuing the Healthy Shot and there should be one. The Dietary Manager (DM) was interviewed on 04/02/14 at 3:15 PM. DM stated any lab results and dietary changes were faxed to the dietary department. She further stated that sometimes the Healthy Shot information would not be faxed but passed on by word of mouth to DT. DM stated the RD or nurse were responsible to	F 325	box for care planning and follow up by Weights and Wounds Committee. The Weights and Wounds Committee will be responsible for monitoring compliance and procuring physician orders to implement, modify or discontinue current interventions. The Weights and Wounds Committee may request additional guidance from the Registered Dietician between routine follow up if indicated. How facility plans to implement the corrective action and evaluate for it□s effectiveness: The DON will monitor the charts of 10 residents that have lab work indicating nutritional risks that require intervention or a history of refusing nutritional supplements. The DON will monitor weekly for proper implementation, compliance, and discontinuation of interventions by the Weights and Wounds Committee and Registered Dietician, if indicated. Audits will be conducted weekly for 4 months to ensure the compliance is achieved and maintained. Audits are reviewed by the QAPI Committee. The QAPI Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.	

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determine if an alternative to the refused Healthy Shot was necessary. She stated she was not sure of the system to alert the RD and that she herself did not know the Healthy Shot was ordered, refused, and/or discontinued.

On 04/02/14 at 3:34 PM the RD stated she expected to be notified of refusal for interventions, i.e. the Healthy Shot so that she could order something else in its place. She stated that if staff had notified DT, he could have followed up on the refusal of the protein supplement. She stated she was unaware of Resident #22's refusal of the Healthy Shot and could have ordered another type of protein that may have been more acceptable to Resident #22.

The Director of Nursing (DON) stated during interveiw on 04/02/14 at 3:49 PM that Resdient #22 would not have been a candidate for the addition of a lot more calories but more protein could have been added to her diet as an alternative. She further stated on 04/02/14 at 4:26 PM there should have been an order for the discontinuation of the Healthy Shot. She also stated the next laboratory testing of her albumin would have occurred 6 months after the initial testing.

On 04/03/14 at 10:27 AM, Nurse #1, who wrote the note on the MAR that discontinued the Healthy Shot due to refusal was interviewed by phone. She stated the original order was not a physician's order as it was written by the RD and therefore she did not write a discontinued order for the physician. She stated she could not recall if she notified the RD of the refusal and would have to refer to the nursing notes.