PRINTED: 02/26/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2275 RUIN CREEK ROAD HENDERSON, NC 27536	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
SS=G	The facility must conda comprehensive, according reproducible assessment functional capacity.  A facility must make a assessment of a resident assessment by the State. The assident fication and dem Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior prescribe physical functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sur the additional assession areas triggered by the Data Set (MDS); and Documentation of paragraph of the set of the product of t	duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information;  atterns; ng; and structural problems; d health conditions; status;		TITLE		2/4/16

01/29/2016 **Electronically Signed** 

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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		345316	B. WING		01/07/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	,
SENIOD C	ITIZENS HOME			2275 RUIN CREEK ROAD	
SENIOR	ITIZENS HOWE			HENDERSON, NC 27536	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 272	Continued From page	e 1	F 272	2	
	This REQUIREMENT by:	Γ is not met as evidenced			
	_ ·	riew and staff interviews, the		1.The MDS nurse did a comprehensi	ve
		rehensively assess the		significant change assessment for	. •
		eceiving a gastrostomy tube		resident #69 on 2-4-16. The	
	feeding for 1 of 4 resi	idents (Resident #69)		comprehensive significant change	
	reviewed for Nutrition	١.		assessment addressed the residents	
				nutritional needs and included the	
	The findings included	<b>i</b> :		dieticians assessment.  The dietician did a nutritional assessment.	nent
	Resident #69 was ad	lmitted to the facility from a		on 1-16-16 for resident #69. The	
		with a cumulative diagnoses		nutritional assessment included protei	in,
		tes, a history of aspiration		calories and fluid amounts. On 2-11-1	
	pneumonia, and plac	ement of a gastrostomy tube		protein powder was added and TP/AL	.В
	on 10/21/15 (a surgio	cal opening into the stomach		lab was drawn on Resident #69.	
	whereby a feeding tu	be may be inserted).		When the new dietician reassessed	
				resident #69 on 2-12-16, the current to	
		nission orders dated 10/29/15		feeding order met the residents nutriti	onal
	_	g tube feeding instructions:		needs.	
		abetisource via gastrostomy		0. All tube feel assistants	- 41
	-	s a bolus feeding (provided		2. All tube fed residents were added to	o the
	at one time); 90 ml w and 30 ml of water af	rater flush after each feeding		February MDS schedule to have a comprehensive MDS completed by	
		be feeding formulation		2-24-16. The MDS nurse will do the	
		with diabetes and stress		comprehensive MDS. The compreher	nsive
	induced high blood s			assessment on tube fed residents will	
	madoca mgm biood o	agai iovoio.		address residents nutritional needs ar	
	On 10/30/15 at 11:50	) AM. a Physician ' s		will include dieticians assessment. All	-
	Telephone Order was			tube residents had a nutritional	
	· ·	rostomy feeding to Boost		assessment on 1-16-16 and 1-30-16 b	ру
		nula, given as one can (237		dietician. All residents that are fed by	
		oost Glucose Control is a		had an addendum done to most recer	
		n designed for people with		nutrition/feed tube CAA 0n 2-4-16. Th	
	diabetes; it is intende			addendum was done by the MDS nurs	l l
		ing to the manufacturer 's		and was based on dieticians assessm	
	·	Boost Glucose Control is not		The addendum included RD assessm	
		eding formulation. However,		of current feedings and flushes, comp	
	⊢if a healthcare provid	er selected this product for a		usual weight to current weight, compa	red

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NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRES	SS, CITY, STATE, ZIP CODE	•	
SENIOR C	ITIZENS HOME			2275 RUIN CRE	EK ROAD		
OLIMON	THE ENGINE			HENDERSON,	, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORREG ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	Continued From page tube feeding, 5 cans	e 2 (1185 ml) were required to	F 2		or not current feeding me	et current	
	meet 100 percent of the Intake (RDI) for esset Boost Glucose Control as ordered, yielded 1 of protein and 792 ml (exclusive of the water not receive any nutrit resident's medical reassessment of her nuapproximation of the tube feeding ordered.  The resident's admit (MDS) assessment desident #69 had see skills for daily decision totally dependent on the second received the second resident #69 had see skills for daily decision totally dependent on the second received received the second received	the Recommended Daily Intial nutrients. Four cans of pol provided every 24 hours, 1000 calories with 56 grams of free water daily or flushes). Resident #69 did ion or fluids by mouth. The ecord did not include an utritional needs or an nutritional content of the sesion Minimum Data Set ated 11/2/15 indicated verely impaired cognitive or making. The resident was estaff for all of her activities of		needs and All g tube newly con all g tube being met The dietic assessme by G tube nutritional quarterly.  3. The ME committee portion of assessme assessme All Reside	d evaluation of TP/ALB resident were assessed tracted dietician on 2-12 residents nutritional needs. Can will do a nutritional ent monthly on all resides. The dietician will do a l assessment on all resides and will complete nutricithe comprehensive ents based on the dieticient ents will be weighed on	levels. d by the 2-16 and eds are ents fed dents ht itional	
	be 61 inches tall and MDS assessment ind more of her calories a via a tube feeding.  A review of Resident Assessment (CAA) S addressed the use of summary read:  " Feeding Tube: Trig feeding tube present. consider: she has dx failure, sepsis, a-fib (congestive heart faile advanced dementia, others. She is NPO (fluids and nutrition arwas present upon ad Nursing Facility). She	ummary dated 11/3/15 a feeding tube. The  gered by Resident has a Resident factor to (diagnosis) of respiratory atrial fibrillation), CHF ure), DM (diabetes), HTN (hypertension) and nothing by mouth) and all e via feeding tube. Tube mission to SNF (Skilled		weight coincludes A Developed Nurse. The all weights monthly be a month, months. Fed reside weekly be recommended to notifyin Speech the 4. On a meadministration ensure	and at least monthly. To mittee meets twice a value of the weight committee will as at least but not limited pased on weight change 7.5% in 3 months and 1. The committee review a cents nutritional needs on asis and makes nutrition andations as needed. The ndations include but not an dietician, notify doctor merapy, and add suppler monthly basis, for 3 montator will audit all resident the dietician has writter I assessment within 14 centary and add suppler assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has writter I assessment within 14 centary in the dietician has written I assessment within 14 centary in the dietician has written I assessment within 14 centary in the leaf within 14 centa	week and  ff DS review to of 5% in 0% in 6 ill tube a al ese t limited r, refer to ments.  ths the at charts a	

Facility ID: 923449

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	07/2016
NAME OF PROVIDER OR SUPPLIER	
SENIOR CITIZENS HOME  2275 RUIN CREEK ROAD HENDERSON, NC 27536	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 Continued From page 3 is non-communicative. No noted abdominal distention. Current weight is 125 pounds. No referrals, will proceed with care plan to maintain tube and weight." The CAA Summary did not include an analysis of the current weight compared to her usual body weight. The CAA did not address an assessment of the nutritional needs of this resident nor did it address an analysis of the current tube feeding orders and whether the current tube feeding met her nutritional requirements. The CAA did not include information provided by the facility 's consultant dietitian; it indicated no referrals were planned.  A review of Resident #69 's Weight Records included the following: 11/4/15 Weight = 118 pounds; 11/18/15 Weight = 119 pounds; 11/28/15 No weight was noted; and, 12/2/15 No weight was noted.  A Physician 's Telephone Order was written on 12/2/15 for weekly weights due to continuous weight loss (per weight committee). Resident #69 's tube feeding was increased to 320 ml every 6 hours. 320 ml of Boost Glucose Control give nevery 6 hours. 320 ml of Boost Glucose Control give nevery 6 hours yielded approximately 1349 calories with 75 of grams of protein and 1069 ml of free water daily (exclusive of the water flushes). The resident 's medical record did not include an assessment of her nutritional needs or an approximation of the nutritional needs or an approximation of Resident #69 's Weight Record included the following:	

Facility ID: 923449

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345316	B. WING		01/07/2016
NAME OF PROVIDER OR SUPPLIER  SENIOR CITIZENS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536		1 01/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 272	revealed a Stage 2 Resident #69's sa On 12/31/15, a Phy was written to char formulation to Diab feeding at 55 millilit continuous feeding ordered bolus feed provided at 55 ml/h 1584 calories with 1080 ml of free wat feeding water flush record did not inclu nutritional needs or nutritional content of A review of Reside included the followi pounds.  A review of Reside included there were completed for this r assessment was no calorie, protein, and an approximation of free water provided for the resident sind on 10/29/15.	98 pounds. 97 pounds; and, 96 pounds. D PM, the Nurse 's Notes pressure area was found on	F 27	2	
	with the facility 's [	Director of Nursing (DON). ON reported residents '			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345316	B. WING _			01/07/2016
NAME OF PROVIDER OR SUPPLIER  SENIOR CITIZENS HOME  SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 5	F 2	72		
1 2/2	weights were follow Weight Committee. Resident #69's con identified by the Coweekly to follow the assessments or interest as the session of the session of the facility once anoted she hadn't be month. Upon further reported her last nut facility was approximated to Resident #69's She reported the Didid not have any cli whatsoever. When usually checked on feeding when he/sh facility and when dushe indicated residualso reviewed if he/another problem pri assessment date. facility were able to as needed, but acknow had been made sing upon briefly review feeding orders, labor weight loss, the RD something that should be the	The DON acknowledged intinuing weight loss was immittee and she was weighed weights. No other erventions were reported.  We was conducted on 1/6/16 at cility's consultant Registered ing the interview, the red she typically tried to come in month. However, the RD interview in the facility the past er questioning, the RD trition consultation visit to the mately 10 weeks ago and prior admission date of 10/29/15. The tary Manager for the facility inical responsibilities asked, the RD stated she residents receiving a tube in the facility assessment. The for a quarterly assessment was losing weight or had or to the scheduled. The RD reported staff at the contact her for a consultation mowledged no such request the her last visit to the facility. The RD resident #69's tube oratory results and history of stated, "Yeah, that's all have been addressed."	F 2			
	9:56 AM with the fa the interview, the M	ew was conducted on 1/7/16 at cility 's MDS Nurse. During DS nurse reported she veekly Weight Committee				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345316	B. WING _		01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2275 RUIN CREEK ROAD  HENDERSON, NC 27536	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 272		e 6 she was unable to provide concerns identified for	F 2	72	
F 314 SS=G	An interview was corwith the facility's DO facility's consultant residents receiving a formulation and volunutritional needs. Hoshe had not seen the a while. When asket the RD to have reviefeeding regimen to eenough calories to pstated, "Yes." Upgresponsible to ensur		F 3	14	2/4/16
	resident, the facility r who enters the facilit does not develop pre individual's clinical or they were unavoidab pressure sores recei	ehensive assessment of a must ensure that a resident y without pressure sores essure sores unless the condition demonstrates that ole; and a resident having ves necessary treatment and healing, prevent infection and om developing.			
	by: Based on observation record review, the fa	T is not met as evidenced ons, staff interviews, and cility failed to assess and needs of a resident for 1 of 3		1.Resident #69 has had a nutritional assessment done by the dietician. I nutritional assessment included the	Гће

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NAME OF PI	ROVIDER OR SUPPLIER	-	·	STREET ADDRESS, CITY, STATE, ZIP CODE	•
				2275 RUIN CREEK ROAD	
SENIOR C	ITIZENS HOME			HENDERSON, NC 27536	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
F 314	Continued From pag	ge 7	F 314	4	
	sampled residents (	Resident #69) who was at a		protein, calories, and fluid amounts.	「he
	high risk for the pote	ential development of		nutritional assessment was done on	1-16-
	pressure ulcers.			16. Per nutritional assessment, reside	ent
				#69 required additional calories, prote	
	The findings include	d:		and fluid to promote healing and dieta	•
				recommendations were made. Resid	ent
	Resident #69 was admitted to the facility from a			#69□s feeding has been changed.	
		with a cumulative diagnoses		Resident # 69 has an air mattress on	bed.
	which included diabetes, a history of aspiration				
		cement of a gastrostomy tube		2.The dietician did a nutritional	
		cal opening into the stomach		assessment on all at risk resident tha	
	whereby a feeding to	ube may be inserted).		fed via g tube on 1-16-16 and 1-30-10	
	D :: 1 ///00 ! !			ensure nutritional needs were met an	
		mission orders dated 10/29/15		weight is maintained. All residents the	at are
		ng tube feeding instructions:		fed via g tube have had their orders	_
		iabetisource via gastrostomy		changed to an enteral feeding formul	d.
	-	as a bolus feeding (provided			
	· ·	water flush after each feeding after each medication.		3. All residents on admission receive	
		ube feeding formulation		Norton pressure ulcer scale assessm	ont
		with diabetes and stress		A nutritional assessment will be done	
	induced high blood			dietician within14 days of admission.	•
	induced mgm blood .	sugai icveis.		resident may also be assessed for	Λ
	On 10/30/15 at 11:5	0 AM, a Physician ' s		additional pressure relief devices,	
		as received to change		nutritional supplements, need for the	rapy
	-	strostomy feeding to Boost		intervention, more frequent turning ar	
		mula, given as one can (237		repositioning, and more frequently	
		Boost Glucose Control is a		toileting. When a resident develops a	
		on designed for people with		pressure ulcer the facility will initiate	
		ed for use as an oral		and add arginade, vitamin C, Zinc an	
		ding to the manufacturer 's		multi vitamins to promote healing. Or	
	1	Boost Glucose Control is not		wound is observed, a TP/ALB lab is o	
	I -	eeding formulation. However,		and will be drawn every 3 months. Th	
		der selected this product for a		doctor will also be notified. The dietic	
	tube feeding, 5 cans	(1185 ml) were required to		will be notified to do an additional	
	meet 100 percent of	the Recommended Daily		nutritional assessment. The weight	
	Intake (RDI) for esse	ential nutrients. Four cans of		committee meets twice a week and	
	Boost Glucose Cont	rol provided every 24 hours,		includes Administrator, DON, Staff	
	as ordered, yielded	1000 calories with 56 grams		Developer, Social Worker and MDS	

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NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, Z	· · · · · · · · · · · · · · · · · · ·	
CENIOD O	NITIZENIC LIOME			2275 RUIN CREEK ROAD		
SENIOR	CITIZENS HOME			HENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICII	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From pag	e 8	F3	314		
1 314	of protein and 792 m (exclusive of the wat not receive any nutri resident 's medical r assessment of her n approximation of the tube feeding ordered A review of Resident Assessment & Revie the resident was 61 i pounds (#). No skin ulcers were reported retention) were made assessment of press Norton Pressure Ulc on 10/29/15. The re was 6 on a scale of 8 Norton scale, Reside the potential develop  The resident 's adm (MDS) assessment of Resident #69 had se skills for daily decisio totally dependent on daily living (ADLs). 8 bladder and bowel. reported.  A review of Resident Assessment Summa her risk for the devel The narrative read, in Resident is depende incontinent of bowel developing pressure pressure ulcers at th	all of free water daily er flushes). Resident #69 did tion or fluids by mouth. The record did not include an utritional needs or an nutritional content of the d.  #69 's Admission Nursing ew dated 10/29/15 revealed inches tall and weighed 125 breakdown or pressure d. No notes of edema (fluid de. Resident #69 's sure ulcer potential using the er Scale was also completed sident 's total Norton scale foto 20. Based on the total ent #69 was at a high risk for oment of pressure ulcers.  dission Minimum Data Set dated 11/2/15 indicated everely impaired cognitive on making. The resident was staff for all of her activities of She was incontinent of No pressure ulcers were  #69 's Care Area ary dated 11/3/15 addressed opment of pressure ulcers. In part: "Triggered by ent in bed mobility and and bladder and at risk for		Nurse. The weight common weights and make nutrit recommendations as ne recommendations included to notifying dietician, not speech therapy, and ad On a monthly basis, the nutritional assessment of are fed via g tube and repressure ulcers.  4. On a monthly basis, for administrator will audit at to ensure the dietician houtritional assessment. The performed quarterly, basis, for three months, monitor 2 at risk resident pressure ulcers. After 3 monitoring will be perforted monitoring will be orecord review. The DON residents skin for red are points. The DON will also record to see if they need vitamins. Negative finding monitoring will also be sent meeting for recommend committee on how to de number of negative finding.	ional leded. These de but not limited tify doctor, refer to d supplements. dietician will do a on residents that esidents that have  or 3 months the full resident charts as written a Then the audit will On a weekly the DON will the DON will the to help prevent months the med quarterly. bservation and I observes the leas at pressure led supplements or longs from leted. Negative to the next QA ations from the crease the	

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	ROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 275 RUIN CREEK ROAD IENDERSON, NC 27536	
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F 314	repositioned every referrals, will proceed pressure ulcers. "  A review of Resider 11/3/15 included the Pressure Ulcer-Resider breakdown related incontinence. The improvement of the referral to the facility assessment of the referral to the facility of the referral to the facility assessment of the referral to the referral to the facility assessment of the referral to the facility assessment of the referral to the referral to the facility assessment of the referral to the facility assessment of the referral to the facility assessment of the referral to the referr	ge 9 d. She is turn(ed) and 2 hours and as neededNo ed with care plan to prevent  at #69's Care Plan dated e following area of focus: ident is at risk for skin to decreased mobility and interventions included, in part: ids via feeding tube as erventions did not include a y's consultant dietitian for an resident's nutritional needs an as needed basis).  at #69's medical record ing laboratory results dated in = 5.0 (normal range = in = 2.4 (normal range = is the most abundant protein in a and is frequently used in r general health screening. 2.4 may be indicative of visceral protein depletion.  at #69's Weight Records ing: 11/4/15 Weight = 118	F 314		
	Records included the strength of the strength	11 pounds; 105 pounds; was noted; and,			

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NAME OF PROVIDER OR SUPPLIER  SENIOR CITIZENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  2275 RUIN CREEK ROAD  HENDERSON, NC 27536			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	from 12 on 10/29 to Assessment/Plaincrease 320 ml eve  A Physician 's Telep 12/2/15 for weekly w weight loss (per weig #69 's tube feeding every 6 hours. 320 in given every 6 hours calories with 75.6 gray of free water daily (e flushes). The reside include an assessme an approximation of tube feeding ordered  A review of Resident included the followin 12/9/15 Weight = 96 12/16/15 Weight = 96 12/16/15 Weight = 9 12/23/15 Weight = 9 12/30/15 Weight = 9 On 12/30/15 at 2:00 revealed a Stage 2 p Resident #69 's sact 12/30/15 revealed th 1.4 x 1 x 0 centimete present. The date of as 12/30/15.  On 12/30/15, a Phys was written for the for with normal saline; a every shift until heale	Weight decrease gradual 105 on 11/21. an (A/P): Weight loss: ry 6 hours from 240 "  hone Order was written on eights due to continuous ght committee). Resident was increased to 320 ml ml of Boost Glucose Control yielded approximately 1349 ams of protein and 1069 ml xclusive of the water nt's medical record did not ent of her nutritional needs or the nutritional content of the l.  #69's Weight Record g: pounds; 8 pounds, 7 pounds; and,	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	Continued From page	ge 11	F 3	14		
	once daily, 500 mg and 1 pack of Argina supplement intender to be given twice da (or for 90 days).  On 12/31/15, a Physical was written to change formulation to Diabe feeding at 55 millilities continuous feeding ordered bolus feeding provided at 55 ml/hr 1584 calories with 7 1080 ml of free water feeding water flusher record did not include nutritional needs or nutritional content of Wound Records dat #69 's sacral pressed to centimeter (cm) where the sacral pressed to the sacral pressed to centimeter (cm) where the sacral pressed to the sacral	vitamin C given once daily, aid (an amino acid d to promote wound healing) ily until the area was healed sician 's Telephone Order ge the tube feeding tisource and to initiate this	F 3			
	An observation was sacral pressure ulce 9:37 AM. The woun	made of the resident 's or and treatment on 1/7/16 at d bed was pale with no ted. The wound measured 2				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345316	B. WING			1/07/2016
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COI 2275 RUIN CREEK ROAD HENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	revealed there were completed for this re assessment was no calorie, protein, and an approximation of free water provided for the resident since on 10/29/15.  An interview was cowith the facility 's Dupon inquiry, the Duwights were follow Weight Committee. Resident #69 's coridentified and the refollow the weights. reported.  A telephone interview 3:44 PM with the facility in the	t #69 's Medical Record no Nutrition Progress Notes esident. A nutritional t available to estimate her /or fluid needs; nor was there the calories, protein, and/or by the tube feeding ordered e her admission to the facility  Inducted on 1/6/16 at 3:14 PM irector of Nursing (DON). DN reported residents ' ed weekly by the facility 's The DON acknowledged atinuing weight loss was esident was weighed weekly to No other interventions were  In was conducted on 1/6/16 at cility 's consultant Registered ing the interview, the ted her last nutrition the facility was prior to mission date of 10/29/15. D stated she usually checked ing a tube feeding when interventions were  In sessessment. She indicated the feeding were also reviewed weight or had another scheduled assessment date. In available to	F 31	14		
	acknowledged no su	nsultation as needed, but such request had been made the facility. Upon briefly				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE COMF	SURVEY
		345316	B. WING			01/	07/2016
	ROVIDER OR SUPPLIER		•	2:	TREET ADDRESS, CITY, STATE, ZIP CODE 275 RUIN CREEK ROAD IENDERSON, NC 27536	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 314	reviewing Resident # laboratory results, we	69 's tube feeding orders, eight loss, and pressure ulcer	F:	314			
	something that should A telephone interview	stated, "Yeah, that's d have been addressed."  was conducted on 1/7/16 at					
	(MD). When asked he choice of the tube feet volume provided, the	dent 's Medical Doctor ow he decided on the initial eding formulation and MD indicated he would on the hospital regimen upon					
	discharge but may ha the facility had availa Glucose Control). Th	eve went with the formulation ble (referring to Boost					
	fluid restriction. The was maintenance and tube feeding calories judiciously." He est	MD reported his intention dhe wanted to increase the provided to Resident #69, "imated the resident needed alories a day and less than					
	1:33 PM with the faci reported the facility 's reviewed the resident ensure the nutrition for provided met his/her asked if she would have reviewed Resident #6 to ensure the resident						
F 325 SS=G	When asked if she th pressure ulcer was p been avoided, the DO 483.25(i) MAINTAIN	reventable and could have DN replied, " honestly, yes. " NUTRITION STATUS	F:	325			2/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			01/07/2016
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 2275 RUIN CREEK ROAD HENDERSON, NC 27536	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 325	resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that thi	s comprehensive ity must ensure that a able parameters of nutritional weight and protein levels,	F3	325		
	by: Based on observation record review, the fact meet the nutritional in a gastrostomy tube for loss for 1 of 4 sample reviewed for Nutrition.  The findings included Resident #69 was add hospital on 10/29/15 which included diabed pneumonia, and plact on 10/21/15 (a surgious whereby a feeding tube Resident #69 's admidated 10/29/15 included to be give once daily; NovoLog sliding scale basis; at	l: mitted to the facility from a with a cumulative diagnoses tes, a history of aspiration ement of a gastrostomy tube eal opening into the stomach		1. Resident # 69 has had a assessment by dietician on stated was meeting nutrition was adequate nutrition. The assessment included the proand fluid amounts The MDS comprehensive significant of assessment for resident #69 Resident # 69s tube feeding from Isosource to Diabeticson.  2. The dietician did a nutrit assessment on all residents via g tube on 1-16-16 and 1-make sure their nutritional nutrition and the sure their nutritional nutrition and the sure their nutritional nutrition and the sure their nutrition and the sessessment on all residents Residents that are fed via go been changed to an enteral formula. On 1-15-16 the weight reviewed all residents and mappropriate recommendation.	1-16-19 and al needs and nutritional otein, calorie, nurse did a hange on 2-4-16. was changed ource. tional that are fed -30-16 to eeds were be d a nutritional on 1-16-16. tube have feeding ght committee nade	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345316	B. WING			01/	07/2016
	ROVIDER OR SUPPLIER			22	TREET ADDRESS, CITY, STATE, ZIP CODE 275 RUIN CREEK ROAD ENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	included the following 120 milliliters (ml) Dia tube every 6 hours as at one time); 90 ml ward 30 ml of water af Diabetisource is a tube designed for people winduced high blood su On 10/30/15 at 11:50 Telephone Order was Resident #69 's gast Glucose Control form ml) every 6 hours. Be nutritional formulation diabetes; it is intende supplement. According product information, intended as a tube fee if a healthcare provide tube feeding, 5 cans meet 100 percent of the Intake (RDI) for esser Boost Glucose Control as ordered, yielded 1 of protein and 792 ml (exclusive of the water not receive any nutrition resident 's medical reassessment of her nuapproximation of the tube feeding ordered. A review of Resident Assessment & Review the resident was 61 in pounds (#). No skin in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at the resident was 61 in pounds (#). No skin in the same at th	ission orders dated 10/29/15 If tube feeding instructions: Inbetisource via gastrostomy Is a bolus feeding (provided Interest flush after each feeding Iter each medication. Iterest flush effecting formulation Iterest flush after each feeding Iterest flush flush flush Iterest flush flush flush Iterest flush flush flush Iterest flush Iteres	F	325	3. On a monthly basis, the dietician wido a nutritional assessment on resident that are fed via g tube. The dietician wido an assessment on all residents quarterly. The dietician will make recommendations. Depending on the recommendation, it will go to either the kitchen or the doctor. The doctor will decide whether or not to follow the recommendation These recommendations will go to doctor to make a decision. The MDS nurse is on the weight committee and will complete nutritional assessments based on the dieticians assessment. All Residents where weighed on admission and at least monthly. The weight committee meets twice a week and includes Administrate DON, Staff Developer, Social Worker and MDS Nurse. The weight committee will review all weights at least but not limite to monthly. All weights are reviewed monthly and recommendations made based on weight change of 5% in a month, 7.5% in 3 months and 10% in 6 months. The committee review all tube fed residents nutritional needs on a weekly basis and makes nutritional recommendations as needed. These recommendations include but not limite to notifying dietician, notify doctor, refersions and the properties of the properties. Speech therapy, and add supplements 4. On a monthly basis, for 3 months the administrator will audit all resident chart to ensure the dietician has written a nutritional assessment within 14 days of admission. After 3 months, the audit within 14 days of admission. After 3 months, the audit within 14 days of admission. After 3 months, the audit within 14 days of admission.	es ill or, and ed r to .	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			01/	07/2016	
	ROVIDER OR SUPPLIER			22	REET ADDRESS, CITY, STATE, ZIP CODE 175 RUIN CREEK ROAD ENDERSON, NC 27536			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 325	(MDS) assessment did Resident #69 had set skills for daily decision totally dependent on daily living (ADLs).  A review of Resident Assessment (CAA) Saddressed the use of summary read:  "Feeding Tube: Trig feeding tube present consider: she has down failure, sepsis, a-fib (congestive heart fail advanced dementia, others. She is NPO (fluids and nutrition ar was present upon ad Nursing Facility). She remove the tube. She is non-communicative distention. Current we referrals, will proceed tube and weight. "The CAA Summary did the current weight coweight. The CAA did of the nutritional need address an analysis of orders and whether the nutritional require include information principles."	ession Minimum Data Set ated 11/2/15 indicated verely impaired cognitive in making. The resident was staff for all of her activities of #69 's Care Area summary dated 11/3/15 fa feeding tube. The gered by Resident has a Resident factor to a (diagnosis) of respiratory atrial fibrillation), CHF ure), DM (diabetes), HTN (hypertension) and (nothing by mouth) and all e via feeding tube. Tube mission to SNF (Skilled	F3	3325	be performed quarterly. On a monthly basis, for 3 months, the administrator of audit the CAA so fresident who are feby gtube to ensure they have a CAA. A months, the audit will be performed quarterly. Negative findings from these audits will be corrected in the appropriatime. Negative findings will also be set to the next QA meeting for recommendations from the committee how to decrease the number of negative findings.	ed After e ate nt on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345316	B. WING		01/07/2016	
	ROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 275 RUIN CREEK ROAD IENDERSON, NC 27536	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 325	11/3/15 included the Alteration in nutrition tube. There were not which addressed Recare plan. Additional Interventions/Approassessment of the man analysis of the admeeting these need Interventions/Approareferral would be materither initially or on a A review of Residen included the following 11/3/15: total proteing 6.5-8.0), and albuming 3.0-5.5). Albuming is human blood plasma blood test panels for An albumin level of a moderate to severe A review of Residen included the following pounds.  A Nurse's Note dathad non-pitting eder extremity. No other reported.	t #69 's Care Plan dated following area of focus: n related to use of a feeding of Interventions/Approaches esident #69 's weight in the fally, no faches addressed an feesident 's nutritional needs or feeduacy of her tube feeding in faches did not indicate a facted to the consultant dietitian, fan as needed basis.  It #69 's medical record fing laboratory results dated fin = 5.0 (normal range = fin = 2.4	F 325			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345316	B. WING		01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 325	Continued From pag	ge 18	F 32	5	
	included a notation of in part:  "Objective (O): from 12 on 10/29 to Assessment/Pl increase 320 ml ever A Physician 's Telep 12/2/15 for weekly weight loss (per wei #69 's dose of glims mg to 4 mg once da increased to 320 ml Boost Glucose Contyielded approximate grams of protein and (exclusive of the wamedical record did rher nutritional content of A review of Residen included the followir 12/9/15 Weight = 96 A Physician 's Progindicated, "Patier stable."  A review of Residen included the followir pounds.  On 12/16/15 at 4:30	an (A/P): Weight loss:  any 6 hours from 240 "  shone Order was written on veights due to continuous ght committee). Resident epiride was decreased from 8 illy; her tube feeding was every 6 hours. 320 ml of rol given every 6 hours sly 1349 calories with 75.6 dt 1069 ml of free water daily ter flushes). The resident 's not include an assessment of sor an approximation of the fithe tube feeding ordered.  It #69 's Weight Recording:  In pounds;  In pounds;  In the weight Records and the feed 's Weight Records and the feed in th			

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION  LDING		(X3) DATE SURVEY COMPLETED	
		345316	B. WING		0	1/07/2016	
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F 325	Records included the 12/23/15 Weight = 9 12/30/15 at 2:00 revealed a Stage 2 Resident #69 's sac Telephone Order was multivitamin given on given once daily, 50 daily, and 1 pack of supplement used to be given twice daily for 90 days).  On 12/31/15, a Phywas written to change formulation to Diable feeding at 55 millilities continuous feeding ordered bolus feeding provided at 55 ml/hr 1584 calories with 7 1080 ml of free water	esident #69 ' s Weight the following: 27 pounds; and, 26 pounds.  2 PM, the Nurse ' s Notes pressure area was found on crum. A Physician ' s as written to initiate a unce daily, 220 mg zinc to be und mg vitamin C given once Arginaid (an amino acid promote wound healing) to until the area was healed (or esician ' s Telephone Order under the side of the	F 32	5			
	nutritional needs or nutritional content of A review of Resider included the following pounds.  A review of Resider revealed there were completed for this re assessment was no	de an assessment of her an approximation of the f the tube feeding ordered.  at #69 's Weight Records ag: 1/6/16 Weight = 102#  at #69 's Medical Record and Nutrition Progress Notes asident. A nutritional at available to estimate her hor fluid needs; nor was there					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			01/07/2016	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE  2275 RUIN CREEK ROAD  HENDERSON, NC 27536			
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F 325	free water provided be for the resident since on 10/29/15.  An interview was conwith the facility 's Dir Upon inquiry, the DO weights were followed Weight Committee. The DON, the Social the Staff Development reported this Committee and would write the order the resident 's MD known point, the DON reported the DON reported the continuing weight to committee and she was continuing weight to Committee and she was continuing weight to the weights. No other reported.  A telephone interview 3:44 PM with the faci Dietitian (RD). During consultant RD reported to the facility once a second was continuing to the facility once as the continuity of the facility of the facility of the facility of the facility once as the continuity of the facility of the	the calories, protein, and/or by the tube feeding ordered her admission to the facility aducted on 1/6/16 at 3:14 PM feetor of Nursing (DON).  No reported residents of the deekly by the facility of the Committee consisted of the Worker, the MDS Nurse, and the Coordinator. The DON feed would decide if someone feekly weight and if so, she find per facility protocol and let frow of the concerns. At that feet the MD would decide if a find the should be ordered for the feeknowledged Resident #69 to see was identified by the forward was conducted on 1/6/16 at lity of someone find the feet was weighed weekly to follow for interventions were forward the seed she typically tried to come month. However, the RD forward for the facility the past	F3				
	reported her last nutr facility was approxim to Resident #69 's ac She reported the Die did not have any clini whatsoever. When a usually checked on re	ition consultation visit to the ately 10 weeks ago and prior dmission date of 10/29/15. tary Manager for the facility					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
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F 325	She indicated reside also reviewed if he/s another problem prior assessment date. The facility were able to cas needed, but acknown had been made since Upon briefly reviewing feeding orders, labor weight loss, the RD is something that should the feeding orders, labor weight loss, the RD is something that should the facility had a since the facility had available of the feeding orders, labor weight loss, the RD is something that should the facility had a since the facility had available of the feeding orders and the facility had available of	e for a quarterly assessment. Into with a tube feeding were the was losing weight or had in to the scheduled the RD reported staff at the contact her for a consultation owledged no such request the her last visit to the facility. In gresident #69's tube atory results and history of stated, "Yeah, that's did have been addressed."  If was conducted on 1/7/16 at the ent #69's family member, will weight was, "in the 120's family member reported for to and during her pital and facility, the resident may problems with fluid was conducted on 1/7/16 at ident's Medical Doctor flow he decided on the initial enting formulation and the hospital regimen upon ave went with the formulation ble (referring to Boost the physician reported art failure and required a	F 32				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		345316	B. WING		01/07/201	16
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536		
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F 325	Continued From page	e 22	F 325			
	Resident #69, " judio resident needed appr day and less than 100 this goal.	iously. " He estimated the oximately 1000 calories a 00 ml fluid daily to achieve				
F 332	1:33 PM with the facility 's reviewed the facility 's reviewed the resident ensure the formulation his/her nutritional need indicated she had not for quite a while. Whe expected the RD to his tube feeding regime enough calories to prostated, "Yes." Upon responsible to ensure her protein needs, the and the dietitian."	was conducted on 1/7/16 at ity 's DON. The DON is consultant RD normally its receiving a tube feeding to in and volume provided met ids. However, the DON is seen the RD in the building its en asked if she would have ave reviewed Resident #69 'en to ensure she was getting event weight loss, she in inquiry as to who was in the resident was meeting its DON stated, "the doctor in the provided in the resident was meeting in the provided in the resident was meeting in the provided in the provide	F 332		2/4/16	6
SS=D	RATES OF 5% OR M The facility must ensumedication error rates					
	by: Based on observatio interviews, the facility medication error rate evidenced by 2 medic opportunities, resultin of 8%, for 2 of 7 resid	greater than 5% as		1. Medication error reports were writte on resident #6 and resident # 53. The doctor was notified and the responsible party was notified. There was no adver outcome for resident #6 or Resident # One nurse that was involved attended inservice on 2-3-16 by SDC. The other nurse involved had passed away.	se 53.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		345316	B. WING _			1/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 2275 RUIN CREEK ROAD HENDERSON, NC 27536	P CODE	
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F 332	Continued From page The findings included 1) A review of the far Nasogastric/Gastric Administration " (no following procedural "6. Flush the tube to administration with 1 Flush with 1-2 of medication administration and process and proces	de 23 de:  acility 's policy, " Tube Medication t dated) included the guideline: pefore and after medication -2 ounces of water. unces water between ration. "  mitted to the facility on ative diagnoses included ant of a gastrostomy tube (a at the stomach whereby at inserted).  t #6 's physician 's cluded a current order for 50 lililiters (ml) docusate liquid to 100 mg) via gastrostomy	F3		cility do not have ed by high med for all nursing staff eld on 2-3-16 by accurate an and proper atton via g-tube ervice included tration, the an versus sennal er storage of at be stored in tharmacy audit the Staff resing inservice on the inservice will a Gtube med and storage, and dication and administration ten on MAR.  For 3 month, the arse during med be on 2 gives meds by ident by g tube.	
	An interview was con 1/6/16 at 1:30 PM. I acknowledged she fl after administering the			Sunday. The DON will romonitored. After 3 month monitor on a quarterly be months, Pharmacy will will during a med pass also the pharmacy will also months from a Negative findings from a	otate shifts to be as the DON will asis. For 3 watch one nurse After 3 months nonitor quarterly.	

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		COMPLETED
	345316	B. WING		01/07/2016
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water before mediciphysician's order is lift no order was writ reported she would tube with water after administered.  An interview was considered with the facility's During the interview her expectation was gastrostomy tube with medication administicated that she had placement and if it is typically flush the tual disconsidered with the Don gastrostomy tube to an after medication accordance with the also reported there nursing staff in regard administration for a tube.  2) On 1/6/16 at 8:5 preparing medicatic Resident #53. The	ation administration if a specifically indicated to do so. ten for this, the Nurse #2 only flush the gastrostomy er a medication was  and onducted on 1/6/16 at 1:35 PM Director of Nursing (DON).  And the DON was asked what is in regards to flushing a with water before and/or after stration. The DON reported is for anyone else, but herself would check tube was okay, she would not able with water before cation.  We was conducted on 1/7/16 at ON. During the follow-up indicated she would expect a be flushed with water before in administration in the facility 's policy. The DON was a need to educate the ards to medication aresident with a gastrostomy  33 AM, Nurse #1 was observed one for administration to medications pulled for	F 332	corrected. Negative findings will sent to the next QA meeting for	
	Continued From parawater before medically administering medication accordance with the administration for a tube.  Revioler or Supplier  Summary (EACH DEFICIENT REGULATORY OF CONTINUED FROM PARAMETER REGULATORY OF CONTINUED FROM PARAMETER REGULATORY OF CONTINUED REGULAT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24 water before medication administration if a physician 's order specifically indicated to do so. If no order was written for this, the Nurse #2 reported she would only flush the gastrostomy tube with water after a medication was administered.  An interview was conducted on 1/6/16 at 1:35 PM with the facility 's Director of Nursing (DON). During the interview, the DON was asked what her expectation was in regards to flushing a gastrostomy tube with water before and/or after medication administration. The DON reported she could not speak for anyone else, but indicated that she herself would check tube placement and if it was okay, she would not typically flush the tube with water before administering medication.  A follow-up interview was conducted on 1/7/16 at 1:33 PM with the DON. During the follow-up interview, the DON indicated she would expect a gastrostomy tube to be flushed with water before and after medication administration in accordance with the facility 's policy. The DON also reported there was a need to educate the nursing staff in regards to medication administration for a resident with a gastrostomy tube.  2) On 1/6/16 at 8:53 AM, Nurse #1 was observed preparing medications for administration to Resident #53. The medications pulled for administration included one tablet from a stock bottle containing 8.6 milligrams (mg) senna and	CORRECTION    A BUILDING	ROUNDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24 water before medication administration if a physician 's order specifically indicated to do so. If no order was written for this, the Nurse #2 reported she would only flush the gastrostomy tube with water after a medication was administered.  An interview was conducted on 1/6/16 at 1:35 PM with the facility 's Director of Nursing (DON). During the interview, the DON was asked what her expectation was in regards to flushing a gastrostomy tube with water before and/or after medication administration. The DON reported she could not speak for anyone else, but indicated that she herself would check tube placement and if it was okay, she would not typically flush the tube with water before and after medication.  A follow-up interview was conducted on 1/7/16 at 1:33 PM with the DON During the follow-up interview, the DON busing the follow-up interview, the DON indicated she would expect a gastrostomy tube to be flushed with water before and after medication administration in accordance with the facility 's policy. The DON also reported there was a need to educate the nursing staff in regards to medication administration in accordance with the facility 's policy. The DON also reported there was a need to educate the nursing staff in regards to medication administration in accordance with the facility 's policy. The DON also reported there was a need to educate the nursing staff in regards to medication administration in accordance with the facility 's policy. The DON also reported there was a need to educate the nursing staff in regards to medication administration in accordance with the facility is policy. The DON also reported there was a need to educate the nursing staff in regards to medication administration in accordance with the facility is policy. The DON also reported there was a need to educate the nursing staff in regards to medication administrat

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			<u> </u>	(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			01/	07/2016
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F 332	Resident #53.  A review of Resident medication orders incoming senna laxative to mouth twice daily.  An interview was con 1/6/16 at 9:45 AM. Us January 2016 Medic (MAR) and the manufatock bottle of the ser Resident #53, the nuadministered to Resident #53, the nuadministered to Resident administered to Resident in the combination medication (containing active ingredient) was kept on the medication the combination medisenna and docusate residents usually received Resident #5 tablet containing senre senna/docusate tablet.  An interview was con Director of Nursing (During the interview, expectation would be medications as order noted that if the order resident should have DON stated, "They (read the order and fo 483.35(a) QUALIFIED.	#53 's physician 's cluded a current order for 8.6 be given as one tablet by ducted with Nurse #1 on pon review of Resident #53 'cation Administration Record facturer 's labeling on the ma/docusate tablet given to be acknowledged the tablet dent #53 during the ation was not the medication e confirmed the prescribed g 8.6 mg senna as a single is available in the floor stock on cart. Nurse #1 indicated dication containing both was the medication eived. However, she is should have been given a ma only, not the combination of the containing both was the medication sived. However, she is should have been given a ma only, not the combination of the nurses to give end by the physician. She is was just for senna, then the been given only senna. The (the nurses) just need to	F3				2/4/16
SS=D		J.L. T. T. W. SINEOTON					

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345316	B. WING		01/07/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 361	full-time, part-time, or lf a qualified dietitian facility must designar director of food servi scheduled consultation. A qualified dietitian is upon either registration Dietetic Registration Association, or on the or experience in ider planning, and implementation.	oloy a qualified dietitian either r on a consultant basis.  is not employed full-time, the te a person to serve as the ce who receives frequently on from a qualified dietitian.  s one who is qualified based on by the Commission on of the American Dietetic e basis of education, training, natification of dietary needs, nentation of dietary	F 30	61	
	by: Based on observation interviews, the facility nutritional assessment interventions for weight mechanically-altered reviewed (Resident Freceiving an enteral Freceiving and enteral Freceiving and place on 10/21/15 (a surgion whereby a feeding to Resident #69 's admits a sample of the freceiving and place on 10/21/15 (a surgion freceiving free free free free free free free fre	diets for 2 of 2 residents #69 and Resident #23) tube feeding.		1. On 1-16-16, the dietician did a nutritional assessment on resident; and Resident # 23. The tube feedin changed for both residents. Both residents get an enteral feeding for Resident #23 was referred to Speed therapy. Resident #23 is receiving SOT services.  2. Nutritional assessments were do all residents that may be in need of mechanically altered diet. All reside being fed via g tube have been chat to an enteral feeding formula. All rebeing fed via g tube have had a nut assessment by dietician. The dietic do an assessment on all g tube resimonthly. The dietician will do an assessment on all residents quarter tube fed residents were added to the February MDS schedule to have a	mula. ch ST and ne on a ents nged sidents tritional ian will idents

Facility ID: 923449

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
		345316	B. WING _			01	/07/2016
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OFNIOD OITIZENO HOME				22	275 RUIN CREEK ROAD		
SENIOR CITIZENS HOME				Н	ENDERSON, NC 27536		
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F 361 Continued Fron	n page	e 27	F 3	361			
120 milliliters (r tube every 6 ho at one time); 90 and 30 ml of wa Diabetisource is designed for per induced high black On 10/30/15 at Telephone Ordan Resident #69 's Glucose Control ml) every 6 hou nutritional formation of the feeding, 5 meet 100 percentage fube feeding, 5 meet 100 percentage functions as ordered, yield of protein and 7 (exclusive of the not receive any resident 's meet assessment of approximation of tube feeding or The resident #69 houself of potally dependent	nl) Dia burs as o ml w ater af is a tub cople v cood si 11:50 er was is gast of form tende ccordi ation, I ube fe corvid cans ent of f e esse Contro ded 1 fe water nutrit dical re- ber of the dered admin ent of the dered admin ent of the dered admin ent of the dered admin ent of the dered	abetisource via gastrostomy a a bolus feeding (provided ater flush after each feeding ter each medication. The feeding formulation with diabetes and stress agar levels.  AM, a Physician 's a received to change rostomy feeding to Boost ula, given as one can (237 post Glucose Control is a designed for people with d for use as an oral ing to the manufacturer 's Boost Glucose Control is not eeding formulation. However, for selected this product for a (1185 ml) were required to the Recommended Daily intial nutrients. Four cans of all provided every 24 hours, 1000 calories with 56 grams of free water daily the flushes). Resident #69 did for or fluids by mouth. The decord did not include an attritional needs or an inutritional content of the	F 3	361	comprehensive MDS completed by 2-24-16. The staff developer audited a residents physician order and checked audit to the snack sheet on 1-28-16. Signed developer then made appropriate refer to Speech Therapy.  3. On 1-19-16, the facility signed a contract with Health Care Services Group to provide the facility with a dietician. Comonthly basis, the dietician will do a nutritional assessment on residents the are fed via g tube and residents with pressure ulcers. On a monthly basis, the dietician will do a nutritional assessment on residents that are fed via g tube. The dietician will do an assessment on all residents quarterly. The dietician will make recommendations. Depending of the recommendation, it will go to either the kitchen or the doctor. The doctor will decide whether or not to follow the recommendation. The MDS nurse is of the weight committee and will complet nutritional portion of the comprehensive assessments based on the dietician assessment. The weight committee will review all weights at least but not limite to monthly. All weights are reviewed monthly and recommendations made based on weight change of 5% in a month, 7.5% in 3 months and 10% in 6 months. The committee review all tube fed residents nutritional needs on a weekly basis and makes nutritional recommendations as needed. These recommendations include but not limit to notifying dietician, notify doctor, reference and to the staff of the commendations include but not limit to notifying dietician, notify doctor, reference and the staff of the commendations include but not limit to notifying dietician, notify doctor, reference and the staff of the commendations include but not limit to notifying dietician, notify doctor, reference and the commendations include but not limit to notifying dietician, notify doctor, reference and the commendations include but not limit to notifying dietician, notify doctor, reference and the commendations include but not limit to notifying dietician, notify doctor, reference and the commendations include but n	d all the the traff rals oup on a at the enter on a rill on e e e e e e e e e e e e e e e e e e	

Facility ID: 923449

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F 361	more of her calories via a tube feeding.  A review of Residen Assessment (CAA) addressed the use of summary read:  "Feeding Tube: Trifeeding tube present consider: she has of failure, sepsis, a-fib (congestive heart fare advanced dementian others. She is NPO fluids and nutrition as was present upon a Nursing Facility). Someove the tube. Someone is non-communicating distention. Current referrals, will proceed tube and weight. "The CAA Summary the current weight of the nutritional new address an analysis orders and whether her nutritional requirement include information consultant dietitian; planned.  A review of Resident 11/3/15 included the	dicated she received 51% or and 501 milliliters or more  It #69's Care Area Summary dated 11/3/15 of a feeding tube. The  ggered by Resident has a t. Resident factor to lx (diagnosis) of respiratory (atrial fibrillation), CHF illure), DM (diabetes), HTN (hypertension) and Incothing by mouth) and all lare via feeding tube. Tube dmission to SNF (Skilled the does not attempt to the does not move often. She live. No noted abdominal live with care plan to maintain  did not include an analysis of compared to her usual body d not address an assessment leds of this resident nor did it of the current tube feeding the current tube feeding met rements. The CAA did not provided by the facility's it indicated no referrals were	F 36	4. On a monthly basis, for 3 madministrator will audit all reside to ensure the dietician has writt nutritional assessment within 14 admission. After 3 months, the be performed quarterly. On a mbasis, for 3 months, the administrational audit the CAA of sof resident who y gtube to ensure they have a 3 months, the audit will be performed quarterly. Negative findings from audits will be corrected in the attime. Negative findings will also to the next QA meeting for recommendations from the comhow to decrease the number of findings	ent charts een a 4 days of audit will nonthly strator will no are fed CAA. After ormed m these ppropriate o be sent	
	tube. There were no	n related to use of a feeding o Interventions/Approaches esident #69 ' s weight in the				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345316	B. WING		01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	
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F 361	assessment of the an analysis of the a meeting these need Interventions/Approreferral would be m	ally, no paches addressed an resident 's nutritional needs or dequacy of her tube feeding in	F 36 <sup>-</sup>		
	included the following 11/3/15: total prote 6.5-8.0), and album 3.0-5.5). Albumin is human blood plasm blood test panels for An albumin level of	nt #69's medical record ing laboratory results dated in = 5.0 (normal range = in = 2.4 (normal range = is the most abundant protein in in and is frequently used in in general health screening. 2.4 may be indicative of in visceral protein depletion.			
	A review of Resider included the following 11/4/15 Weight = 11/11/15 Weight = 11/18/15 Weight = 11/25/15 No weight 12/2/15 No weight 12/2/15 No weight 12/2/15 No weight 12/10/15 No weight 11/10/15 No wei	18 pounds. 111 pounds; 105 pounds; was noted; and,			
	12/2/15 for weekly weight loss (per we #69 's tube feeding every 6 hours. 320 given every 6 hours calories with 75.6 g of free water daily (flushes). The residinclude an assessm	phone Order was written on weights due to continuous ight committee). Resident was increased to 320 ml ml of Boost Glucose Control syielded approximately 1349 rams of protein and 1069 ml exclusive of the water ent's medical record did not nent of her nutritional needs or f the nutritional content of the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345316	B. WING		01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	·
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F 361	included the following 12/9/15 Weight = 9/12/16/15 Weight = 9/12/16/15 Weight = 12/23/15 Weight = 12/30/15 Weight = 12/30/15 Weight = 12/30/15 Weight = 12/30/15 at 2:00 revealed a Stage 2 Resident #69 's sa On 12/31/15, a Phywas written to chan formulation to Diaborate feeding at 55 millility continuous feeding ordered bolus fee	ort #69 's Weight Record ing: 6 pounds; 98 pounds. 97 pounds; and, 96 pounds.  D PM, the Nurse 's Notes pressure area was found on crum.  sician 's Telephone Order ge the tube feeding etisource and to initiate this	F 36	,	
	revealed there were completed for this r assessment was no calorie, protein, and an approximation o free water provided	nt #69 's Medical Record e no Nutrition Progress Notes esident. A nutritional of available to estimate her d/or fluid needs; nor was there f the calories, protein, and/or by the tube feeding ordered the her admission to the facility			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		C	(X3) DATE SURVEY COMPLETED		
		345316	B. WING _			01/07/2016
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 2275 RUIN CREEK ROAD HENDERSON, NC 27536	ZIP CODE	
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F 361	with the facility 's Dir Upon inquiry, the DO weights were followed Weight Committee. Resident #69 's contidentified by the Comweekly to follow the wassessments or interview 3:44 PM with the faci Dietitian (RD). During consultant RD reporte to the facility once a moted she hadn 't be month. Upon further reported her last nutr facility was approximate to Resident #69 's as She reported the Dietidid not have any clini whatsoever. When a usually checked on refeeding when he/she facility and when due She indicated resider also reviewed if he/shanother problem prior assessment date. The facility were able to cas needed, but acknow had been made since Upon briefly reviewing feeding orders, labora weight loss, the RD service we	ducted on 1/6/16 at 3:14 PM ector of Nursing (DON). N reported residents 'd weekly by the facility 's The DON acknowledged inuing weight loss was mittee and she was weighed reights. No other ventions were reported.  If was conducted on 1/6/16 at ity 's consultant Registered go the interview, the ed she typically tried to come month. However, the RD en in the facility the past questioning, the RD tion consultation visit to the ately 10 weeks ago and prior dimission date of 10/29/15. Early Manager for the facility cal responsibilities sked, the RD stated she esidents receiving a tube was first admitted to the for a quarterly assessment. Its with a tube feeding were new was losing weight or had to the scheduled the RD reported staff at the contact her for a consultation whedged no such request the relast visit to the facility. Its gresident #69 's tube atory results and history of	F3	361		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345316	B. WING			1/07/2016	
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F 361	with the facility 's D facility 's consultanted residents receiving formulation and volunutritional needs. It is she had not seen that while. When aske the RD to have reviseding regimen to enough calories to patted, "Yes." Uppersponsible to ensume the protein needs, the and the dietitian."  An interview was considered the facility 's A interview, the Admir he expected the conproviding nutritional	anducted on 1/7/16 at 1:33 PM at	F 36	1			
	included protein cal gastrostomy insertic urinary tract infectio A record review of t dated 10/31/15 reve	admitted on 8/3/15. Diagnoses orie malnutrition, dementia, on (feeding tube), anemia, ons, and heart failure.  The MDS quarterly assessment ealed the resident is severely in the resident is totally					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 361	daily living (ADL's) ex required a two-person always incontinent of a gastrostomy tube for mechanically altered.  A record review of the updated care plan on to the feeding tube. monitor for dehydratic aspiration, monitor in keep head of the bed gastrostomy tube planotify physician if disl.  A record review of the 7/15/15 revealed the hospital for gastrosto tube) due to poor ora tube was inserted on readmitted to the faci was started on one control to the faci was started on one co	assist with all activities of accept transfers, which assist. The resident was bowel and bladder and had or feedings and a diet.  The care plan revealed an an all 11/2/15 for nutrition related Approaches included to pon, signs and symptoms of take and output each shift, all elevated, check for cement prior to feedings and	F3	61			
	the tube feeding four noon, 6 pm and midn for any nutrional supp A record review from the Dietary Manager since October 2, 201 indicating Resident #	itten on 8/3/15 to administer times daily at 6 am, 12 ight. There were no orders blements for this resident.  the Administrator revealed had not been to the facility 5. There were no records 23 had been seen or ician since her readmission					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345316	B. WING		01/07/2016
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 361	log which is updated revealed the resident - 50% of her meals meals since August consumed some or tray.  An observation of ream revealed an aler resident. She was a was beginning to fee The meal tray was personal tray was person	he activity of daily living (ADL) deach shift by the NA 's, nt consumes approximately 25 and occasionally 75% of her 2015. The resident also most of the liquids on her esident #23 on 1/6/15 at 8:30 at and oriented to self only sitting upright in bed. NA #1 ed the resident at this time. For each with thin liquids.  For each of the liquids on the erage of 25-50% with each at is on a tube feeding four that had been eating since the her tube feedings. The as placed on 8/3/15 due to the tothive and decreased mued review revealed the dranging from 148 - 152 resident's weight prior to the	F 361		
	lunch. The NA repo the pureed food, bu tried to encourage h reported she would	d usually ate about 25% at red she does not like some of the ones she does like she ner to eat. The NA further sometimes drink all her nes just take sips. The NA			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345316	B. WING		01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 361	An observation of Re 12:45 pm revealed Neat. The resident wa difficulties with swalled An interview with NA revealed the resident dinner meal. She we the whole cup. The no difficulty with swalled A phone interview with 3:07 pm revealed she for the facility. She recome once a month, had not been there for reported she would on a tube feed she without a property with the at 5:00 pm revealed reevaluated if the number of the ST revealed this an ideal candidate to appropriate diet due She further reported to reevaluate this resorder to make any cheat in the standard of the	thad no difficulty with a fed her.  sident #23 on 1/7/15 at A #1 assisting the resident to as observed having no owing.  #2 on 1/7/15 at 4:00 pm to would eat about 25% of her ould drink sips or her liquid or NA reported the resident had allowing.  the Dietician on 1/6/16 at the was the dietary consultant the eported she was trying to but had some issues so she for about 10 weeks. She also assessments on residents alosing weight, had aspiration alem before the quarterly tion, if a resident comes in rould do an assessment on  Speech Therapist on 1/7/15 the resident would be resident would be resident would have been reevaluate to a more to her adequate oral intake, that no referrals were done ident. The ST stated that in langes to the resident 's diet onsult the dietician after	F 36		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		345316	B. WING		01/	/07/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2275 RUIN CREEK ROAD  HENDERSON, NC 27536			
(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 CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 365 SS=D	1/7/15 revealed that sattempts were made a more appropriate direported she had no pand she was not consor choking. She did r was still on a pureed  An interview with the 1/7/15 revealed that he swould be not to sug DON reported that we member to request a family member did not her expectation was to re-evaluate the reside diet. The DON reported dietician has not asse admission after getting placed.  483.35(d)(3) FOOD II INDIVIDUAL NEEDS  Each resident receives food prepared in a for individual needs.  This REQUIREMENT by:  Based on observation interviews, the facility form designed to mee for 1 of 1 residents (residents of the same saturation of the same sat	Nursing Supervisor on she did not know why no to advance Resident # 23 to get. The nursing supervisor problems with swallowing sidered a risk for aspirating not know why the resident diet.  Director of Nursing on the respectation of the nurse 'gest changing the diet. The equally wait for a family change in the diet. If a set suggest a change, then that the Dietician should that the Dietician should that the Dietician should that the assed her since her go a gastrostomy tube.  N FORM TO MEET  The sand the facility provides the designed to meet.  The is not met as evidenced the special state of the second reviews, and staff failed to prepare food in a set individual nutritional needs the sesident #23).	F3	1. Resident #23 has been referred speech therapy on 1-21-16. ST evaresident #23 on 1-21-16. ST wrote to work with resident #23 for 5Xwk f wks. The appropriateness of the	uated orders	2/4/16	
	The findings included	:		mechanically altered diet is being addressed and changes will be mad	e as		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 365	included protein calc gastrostomy insertion urinary tract infection. A record review of the dated 10/31/15 reversion cognitively impaired dependent with one daily living (ADL's) erequired a two-person always incontinent of a gastrostomy tube mechanically altered. A record review of the updated care plan of to the feeding tube, monitor for dehydrat aspiration, monitor in keep head of the begastrostomy tube planotify physician if distanced in the resident was ser gastrostomy tube in poor oral intake and inserted on 7/31/15, to the facility on 8/3/ on one can of tube fube. On 8/6/15, the that the resident mathin liquids and a purious recognition.	dmitted on 8/3/15. Diagnoses orie malnutrition, dementia, in (feeding tube), anemia, ins, and heart failure.  The MDS quarterly assessment alled the resident is severely. The resident is totally assist with all activities of except transfers, which on assist. The resident was if bowel and bladder and had for feedings and a lidiet.  The care plan revealed an in 11/2/15 for nutrition related Approaches included to ion, signs and symptoms of intake and output each shift, delevated, check for accement prior to feedings and slodged.  The resident's record revealed in to the hospital for sertion (feeding tube) due to weight loss. The tube was the resident was readmitted 15. The resident was readmitted 15. The resident was started eeding every six hours via the espeech Therapist ordered by have pleasure feedings of reed diet.	F 368	indicated from the Speech Therapis  2. All resident diets were reviewer staff developer on 1-28-16. Staff developer audited all physicians or checked dietary orders then compa audit sheet to snack sheet. She the made appropriate ST referrals base audit.  3. Therapy manager will ensure completion of resident screening on quarterly basis by observation and/or record review. New Hires will also be orientated on therapy referral forms staff developer inserviced all nursin including prn staff, about therapy reforms on 2-3-16. All nursing staff wi inserviced quarterly on ST referral forms will review all resident diet orders. A months the audit will be quarterly. The staff developer will audit the physici order and dietary order then compa audit sheet to the snack sheet. Neg findings from audit will be corrected Negative findings will also be sent to next QA meeting for recommendation from the committee on how to improductomes.	d by  der and red n ed on  a a or oe . The g staff eferral ill be orms.  eloper After 3 The ans re the astive . o the ons
	the Dietary Manager since October 2, 20	n the Administrator revealed had not been to the facility 15. There were no records #23 had been seen or			

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		345316	B. WING _			01/	07/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 365	on 8/3/15.  An observation of resam revealed an alert resident. She was si was starting to feed the meal tray was pureed.  An interview with Nur's appetite on 1/6/15 resident eats an averaged meal. The resident is times per day. The rewith swallowing or chresident had regular nausea or vomiting a revealed the resident 8/6/15 in addition to 19 gastrostomy tube was the resident 's failure oral intake. The resident oral intake. The resident 's weight programment of the resident 's weight programment of the resident 's weight programment of the resident and usually at abour reported she does not food, but the ones she encourage her to eat she would sometimes sometimes just take resident had no difficushe fed her.  An observation of Resident resident of Resident and resident had no difficushe fed her.	sident #23 on 1/6/15 at 8:30 and oriented to self only tting upright in bed. NA #1 he resident at this time. The	F3	65			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345316	B. WING _		i	01/07/2016
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 2275 RUIN CREEK ROAD HENDERSON, NC 27536	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO  X (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 365	An interview with NA revealed the resident dinner meal. She we the whole cup. The no difficulty with swa or thin liquids.  An interview with the 1/7/15 at 5:00 pm re reevaluated if the nut The ST revealed this an ideal candidate to appropriate diet due She further reported by nursing to reevaluate that attempts were made a more appropriate or reported she had no and she was not cor or choking. She did was still on a pureed An interview with the 1/7/15 revealed that s would be not to sur DON reported that we member to request a family member did in her expectation was re-evaluate the resid diet. The DON reported	ent was observed having no g a pureed diet.  #2 on 1/7/15 at 4:00 pm It would eat about 25% of her ould drink sips of her liquid or NA reported the resident had allowing with her pureed diet  E Speech Therapist (ST) on wealed the resident would be raing staff sent a referral. It is resident would have been to reevaluate to a more to her adequate oral intake. That no referrals were done that no referrals were done that this resident.  E Nursing Supervisor on she did not know why no ento advance Resident # 23 to diet. The nursing supervisor problems with swallowing insidered a risk for aspirating not know why the resident indiet.  E Director of Nursing on her expectation of the nurse in geest changing the diet. The reverse usually wait for a family a change in the diet. If a oot suggest a change, then that the Dietician should lent to a more appropriate rited she was aware that a	F3	365		
	An interview with the 1/7/15 revealed that s would be not to sur DON reported that w member to request a family member did n her expectation was re-evaluate the residuet. The DON repodietician has not ass	e Director of Nursing on her expectation of the nurse ' ggest changing the diet. The ve usually wait for a family a change in the diet. If a ot suggest a change, then that the Dietician should lent to a more appropriate rted she was aware that a				

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 365 F 412 SS=D	The nursing facility man outside resource, §483.75(h) of this par covered under the St dental services to me resident; must, if necessident; must, if necessident; must, if necessident must promptly refer redamaged dentures to the services of the services	emergency de or obtain from in accordance with rt, routine (to the extent ate plan); and emergency set the needs of each essary, assist the resident in s; and by arranging for from the dentist's office; and esidents with lost or a dentist.  This is not met as evidenced on s, resident and staff if review, the facility failed to be replacement of lost edicaid residents that ence (Resident #19).  It:  mitted to the facility on resident in set included difficulty terly Minimum Data Set 5, indicated the resident 's and no concerns were coded or chewing. The MDS under s not coded for dentures.  history reports done by the on 4/28/15, 9/4/15 and indicated Resident #19 had	F 36		oressions up nily , all e needs oresion a Staff changes s, the ts on a re and will ative orrected ings will ing for	2/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345316	B. WING _		0	1/07/2016
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP ( 2275 RUIN CREEK ROAD HENDERSON, NC 27536	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 412	re-aligned on each  During an observat Resident #19 was i and a cup of fruit. See dentures in place. time she had seen been waiting a mor with me on my dent chew without them, Resident #19 indicat have both top and I  During an interview Nurse Supervisor see dental concerns an Nurse Supervisor at waiting for Medicaid Nurse supervisor er complaint was she Nurse Supervisor ir seen Resident #19 of 2015. She indicat doctor for medical of diet was changed of Nurse Supervisor et the physician would clearance. Then the dentist and a refern Medicaid. It could to approval. She was upon request. She the dentist office or current record of de of dentures.  During a follow up i	of listed visits.  ion on 1/5/16 at 2:12PM, n her room eating a sandwich she did not have her bottom She could not recall the last the dentist. She stated "I had ofth for them (staff) to get back tures. Some things are hard to so I do the best I can ". ated her preference was to	F	112		

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		345316	B. WING		01/07/2016
	ROVIDER OR SUPPLIER		22	TREET ADDRESS, CITY, STATE, ZIP CODE 275 RUIN CREEK ROAD ENDERSON, NC 27536	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 412	get back with me. S started hurting, but it they will start hurting as tender in my more plate. "  During a follow-up in 11:30AM, the Nurse had spoken with the order for dentist to creplacement was not done today. She ad for staff to remove the and place them in the being unaware of w currently located at.  During an observation Resident #19 report was a little chewy, it have had an easier what I could with the teeth I could get a g.  During an interview Director of Nursing, would be for staff to them in the provided stated she was awa Resident #19's dent there was no system residents had their owner would inform reside responsible loss or followed up with ins	peen just waiting for them to o far my gums haven 't if it goes any longer I am sure g. Some of the meats are not just, so I just leave it on my  Interview on 1/6/16 at a supervisor stated that she is physician 1/6/16 and the complete referral for our completed therefore it was ded the expectation would be the resident's dentures at night the denture cup. She indicated there the dentures were	F 412		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	(X3	B) DATE SURVEY COMPLETED
		345316	B. WING _			01/07/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	<u> </u>	
(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 COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431 SS=D	for the physician to direplacement. The Somedical clearance was would be sent to Medical completed for the letter had not been completed for ensure such as dentures and appropriate container Administrator added Director of Nursing with the paperwork process for evaluations or rephearing aids.  483.60(b), (d), (e) DELABEL/STORE DRU  The facility must emplied a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is mireconciled.  Drugs and biologicals	ted the expectation would be to a medical letter for denture cial Worker stated once the as completed by the dentist it dicaid for replacement if the a repair or replacement in the Social Worker confirmed and one and the referral had for Medicaid.  In 1/6/16 at 5:03PM, the the expectation was for staff personal items. Staff was ing residents personal items of hearing aids be placed in and put away safely. The the Social Worker and the responsible for ensuring as was complete for referral placement of dentures and all cament of dentures and suggested and disposition of all difficient detail to enable an an; and determines that drug and that an account of all alintained and periodically alintained and periodically sused in the facility must be a with currently accepted and include the y and cautionary	F 4			2/4/16
	instructions, and the	expiration date when				

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		345316	B. WING	<del></del>	01/07/2016	
	ROVIDER OR SUPPLIER	1	:	STREET ADDRESS, CITY, STATE, ZIP CODE  2275 RUIN CREEK ROAD  HENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETION	
F 431	facility must store a locked compartmer controls, and permi have access to the  The facility must propermanently affixed controlled drugs list Comprehensive Drucontrol Act of 1976 abuse, except when package drug distri	State and Federal laws, the III drugs and biologicals in ints under proper temperature to only authorized personnel to keys.  Dovide separately locked, if compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ininimal and a missing dose can	F 43′			
	by: Based on observat facility failed to stor the manufacturer in rooms.  The findings include An observation of tl 1/7/16 at 10:13 AM of 2% - 0.5% dorzo (eye) solution labels stored in the refrige temperature at the 420 Fahrenheit (F). labeled as having b pharmacy on 12/28	NT is not met as evidenced tions and staff interviews, the e a medication as specified by a 1 of 1 medication store  ed:  the medication store room on revealed an unopened bottle lamide-timolol ophthalmic ed for Resident #86 was erator. The refrigerator time of the observation was The ophthalmic solution was been dispensed from the 1/15. The manufacturer 's indicated 2% - 0.5%		1. Resident #86 eye drops were rer from the refrigerator in the med roor 2. All eye drops that don □t require refrigeration have been removed fror refrigerator in the medication room.      3-16, the staff developer inserviced nursing staff including prn staff, on patorage of meds that can and can □t storage of meds that can and can □t stored in refrigerator.      3. On a quarterly basis, the Staff Developer will hold a nursing inserved administration and the inservice include but not limited to Gtube medication administration, proper med storage, general principles of medication administration.  4.On a weekly basis for three month.	m.  Im the On 2- all Droper be ice on e will I and	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	ROVIDER OR SUPPLIER			22	TREET ADDRESS, CITY, STATE, ZIP CODE 275 RUIN CREEK ROAD ENDERSON, NC 27536		
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F 431	Continued From page	e 45	F	431			
F 520	be stored at room ter 77o F.  Dorzolamide-timolol of combination medication A review of Resident Physician Orders revorder for 2% - 0.5% of ophthalmic solution to each eye every morn.  An interview was con AM with the facility 's Upon inquiry, the DO expected this medicatemperature in according to the stored in the residual position.	ealed there was a current lorzolamide-timolol to be instilled as 1 drop into ing.  ducted on 1/7/16 at 11:33 is Director of Nursing (DON). In reported she would have tion to be stored at room dance with the manufacturer. She acknowledged she cited this ophthalmic solution	F	520	DON will audit the medication room an med carts. After 3 months the audit will performed on a quarterly basis by DON On a monthly basis for three months, the pharmacy will audit the med room for proper storage. After three months the pharmacy will monitor on a quarterly basis. Negative findings from monitoring will be corrected. Negative findings will also be sent to the next QA meeting for recommendations from the committee how to improve outcomes.	l be N. he ng I	2/4/16
SS=D	COMMITTEE-MEMB QUARTERLY/PLANS  A facility must maintal assurance committee nursing services; a pl facility; and at least 3 facility's staff.  The quality assessment committee meets at least assurance activities with respect to and assurance activities develops and implements.	in a quality assessment and consisting of the director of hysician designated by the other members of the					

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F 520	except insofar as succompliance of such or requirements of this succompliance of such or requirements of this succompliance of such or requirements of this succept of said of succept of s	tary may not require ords of such committee on disclosure is related to the committee with the section.  To the committee to identify efficiencies will not be used as of the committee of the ty's Quality Assessment and form the failed to maintain the area and monitor these of committee put into place in as for two recited ere originally cited in April of the areas of a medication ore (F332) and storage of the continued failure of the deral surveys of record show by 's inability to sustain an urance Program.	F	1. Medication storage and error rate will be discussed and the plan of correction for will be discussed. The facility educate the QA committee will on the facility QA policy by towner.  3. The QA committee will for the 6 months then will requarterly meetings. Audits, reports and items of interest reviewed at the meeting.  4. Audits, consulation report interest will be presented meeting. The committee will discuss the information for pand make re- evaluations if	at QA meeting or the two tags ty owner will re on the facility be re educated the facility meet monthly esume consultation t will be orts and items at the QA I review and possible trends	

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F 520	Resident #53) obseto During the recertific facility was cited for medication error rat medication errors w 29 opportunities du observation, resultir rate. The facility fait error rate of 5% or I recertification surveto) F431: Labeling drugs. Based on obinterviews, the facility as specified by the medication store roor During the recertific facility was cited for and properly dispose clean storage envirocarts observed for reacility failed to ensure properly on the curron An interview was consulted buring the interview the facility 's A interview conducted During the interview the facility 's QAA (Committee member Director of Nursing, assessment) Nurse consultant pharmac The Administrator in met to review and consultant propersion of the consultant pharmac The Administrator in met to review and consultant propersions.	7 residents (Resident #6 and rived during medication pass.  Pation survey of 4/16/15, the F332 for failure to maintain a reless than 5%. Three rere identified from a total of ring the medication passing in a 10% medication error led to maintain a medication ess on the current y.  and storage of biologicals and servations and staff ty failed to store a medication manufacturer in 1 of 1	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			01/07/2016	
NAME OF PROVIDER OR SUPPLIER  SENIOR CITIZENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE  2275 RUIN CREEK ROAD  HENDERSON, NC 27536			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETI DATE		
F 520	accuracy of the Med Records (MARs), an indicated staff were changes in the facilit deficiencies from pro- systems related to b	ication Administration Id resident weights. He expected to monitor and audit Ity's system related to evious years. He reported oth the F332 (medication bired medications) citations	F	520			