

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345346	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 4/2/2008
NAME OF PROVIDER OR SUPPLIER FOREST VIEW REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC		
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F 312	<p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to provide hair care for 2 of 12 sampled residents who needed extensive to total assistance for personal hygiene. (Residents #11 and #12)</p> <p>Findings included:</p> <p>1. Resident #11 was admitted to the facility on 8/2/06. The cumulative diagnoses list included Alzheimer's, Dementia with Behavior Disorder, Depressive Disorder, and Status Post Hip Fracture 9/26/05-Difficulty walking.</p> <p>The annual Minimum Data Set (MDS) dated 5/22/07 and the most recent quarterly MDS dated 1/21/08 revealed the resident was coded with short and long term memory problems and moderately impaired daily decision making skills. She required extensive assistance with personal hygiene (hair care).</p> <p>The plan of care updated 1/21/08 revealed, "Staff will perform resident's daily Activities of Daily Living need, allowing the resident to do as much as she can for herself."</p> <p>Observations on 4/1/08 at 1:15 P.M., during a dining observation, and at 4:05 P.M. in the hallway, revealed Resident #11's hair was uncombed. The plaits were matted and loosened on the ends.</p> <p>During an interview on 4/2/08 at 9:45 A.M., Nurse Aide #2 (NA) who was assigned to care for Resident #11 on 4/1/08 and 4/2/08 stated, "The resident's hair does get combed, if I have the time, I usually do it, after I am finished feeding and giving care to my other assigned residents." NA#2 indicated that providing hair care was a part of morning care for residents and Resident #11 did not resist care during personal care.</p> <p>On 4/2/08 at 10:00 A.M., in the Activity Room, revealed Resident #11's hair continued to be matted and plaits loosened on the ends.</p> <p>On 4/2/08 at 10:45 A.M., an interview with the Director of Nursing (DON) confirmed that the resident's hair was expected to be combed with daily care, when needed. She indicated that as of this date (4/2/08) she had delegated the follow up of resident's personal care to the Unit Managers.</p> <p>2 Resident #12 was admitted to the facility on 12/12/06. The cumulative diagnoses list included Alzheimer's, Muscle Weakness, Dementia, and Mood Disorder.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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F 312	<p>Continued From Page 1</p> <p>The annual Minimum Data Set (MDS) dated 12/6/07, coded Resident #12 with short and long term memory problems and moderately impaired daily decision making skills. She required total assistance with personal hygiene (hair care).</p> <p>The plan of care dated 12/12/07 revealed, "Staff will perform resident's daily Activities of Daily Living need, allowing the resident to do as much as she can for herself."</p> <p>Observations on 4/1/08 at 1:00 P.M., during a dining observation, and at 4:10 P.M. in the Activity room, revealed Resident #12's hair was uncombed. The plaits were matted and loosened on the ends.</p> <p>On 4/2/08 at 10:10 A.M., an observation revealed Resident #12's hair continued to be matted and plaits loosened on the ends.</p> <p>On 4/2/08 at 10:15 A.M., an interview with Nurse Aide #2 (NA) who was assigned to care for Resident #12 on 4/1/08 and 4/2/08 indicated that Resident #12's hair was combed (if time permitted), after she finished feeding and giving care to her other assigned residents. NA#2 also revealed that she did not know how to braid the resident's hair, but would ask other nursing aides for assistance. She did not know when the resident's hair was last combed and the resident was not resistive to care.</p> <p>On 4/2/08 at 10:45 A.M., an interview with the Director of Nursing (DON) confirmed that the resident's hair was expected to be combed with daily care, when needed. She indicated that as of this date (4/2/08) she had delegated the follow up of resident's personal care to the Unit Managers.</p>
F 519	<p>483.75(n) TRANSFER AGREEMENT</p> <p>In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.</p> <p>The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Physician interview, staff interview, and record review the facility failed to provide medical information for care and treatment of 1 of 6 residents (Resident #3) who was transferred to the hospital for</p>

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F 519	<p>Continued From Page 2</p> <p>evaluation. The findings include:</p> <p>Resident #3 was admitted to the facility on 10/31/07 with the diagnoses of Subdural Hematoma and Alzheimer's Dementia.</p> <p>Record review of the nurse's note dated 03/10/08 at 10 p.m. read, "Resident unable to sit up or stand up. C/O (complained of) very weak bilaterally. No c/o pain but slightly slurred speech. Ate 15% of supper. Mental changes with memory. Bilateral grips WNL (within normal limits) on upper and lower extremities. VS (vital signs) 98.0, 88, 18, 142/82. Notified the (name of the Physician) and ordered to send out for evaluation of possible stroke. (Name of ambulance service) and left message to (Responsible Party)."</p> <p>Record review of the nurse's note dated 03/11/08 at 10:30 a.m. read, "Returned from (name of hospital). Slurred speech." "Possible TIA (Transient Cerebral Ischemic Attack)."</p> <p>Record review of the nurse's note dated 03/13/08 at 1 p.m. read, "Groaning and grunting, drooling at mouth unable to state anything. Physician called, (order) to go to (name of hospital) to evaluate. (Name of transport service) called for transfer."</p> <p>Record review of the nurse's note dated 03/13/08 at 1:30 p.m. read, "(Name of transport service) came and stated Resident should go by 911. 911 called and took him (Resident #3) at 2:20 p.m. No change in condition (since 03/13/08 at 1:30 p.m.)."</p> <p>No documentation was found in the nurse's notes to show that the Nurse (Nurse #4) prepared and sent current medical information related to Resident #3 for his care and treatment at the hospital he was being transferred to.</p> <p>During an interview on 04/02/08 at 3:05 p.m. the Director of Nurses stated that it was the practice of the facility to send the transfer sheet, the face sheet (contains code status and family contact), the medication list, and any other pertinent information needed when sending residents out to the hospital.</p> <p>During an interview on 04/02/08 at 3:50 p.m., the Physician that treated Resident #3 at the emergency room on 03/13/08 said, "(Name of Resident #3) came to the emergency room without any medical information (on 03/13/08). No medical information, code status, or family contact came with the patient (Resident #3). Finally after 12 hours and many phone calls to the facility I received the information. No one at the facility could explain why he was not sent with the information or why it took so long to get the information."</p> <p>During a telephone interview on 04/03/08 at 10:30 a.m. Nurse #4 indicated that she always sends the "transfer sheet, the face sheet, the medication list, and any other information needed" when sending residents out to the hospital. She indicated that she sent the usual paperwork with Resident #3 to the hospital when he went on 03/10/08 and on 03/13/08. Nurse #4 indicated that she knew that she had filled out the paperwork and sent it with Resident #3 on both dates because the transfer form was a duplicate form, one (1) was sent with the Resident and one (1, the duplicate copy) was kept at the facility in a book at the nurses' station. Nurse #4</p>
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F 519	<p>Continued From Page 3</p> <p>indicated that she would fax a copy of the transfer form for Resident #3 that was dated 03/13/08.</p> <p>Nurse #4 stated in an interview on 04/07/08 at 2:30 p.m. that she looked in the book at the nurses' station and found the transfer copy for Resident #3 dated 03/10/08 but that she was not able to find the duplicate transfer copy for Resident #3 dated 03/13/08.</p>		