STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____ MAR 2 3 2011	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and family member interview and record review the facility failed to provide activities for dependent cognitively impaired resident for 1 of 3 residents. (Resident # 43) Findings: Resident #43 was admitted to the facility on 3/23/2007 with cumulative diagnosis of severe dementia. According to the annual minimum data set (MDS) resident #43 was totally dependent on the staff for all activities of daily living. During a telephone interview on 03/01/11 at 11:15 AM with the resident's family member revealed we have asked the activities director to bring Resident#43 to the singing activities with the other residents. They also verbalized concern that Resident #43 was left alone with the lights off in the room a lot. The family member stated "I wish they(the staff) would get her up in the chair and get her out of her room more often; other then when I ask them to do it." Review of resident #43's care plan dated 10/14/10 revealed interventions for 1:1 room activities for this resident.	F 248	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **F 248** **Corrective Action for Resident Affected:** For Resident #43, the Activities Director/Volunteer made 1:1 visits with resident on several occasions (see **Attachment A**) and will make 1:1 visits with resident at least twice a week. The resident will be assisted OOB and taken to activities by the CNA assigned to her every Thursday as the residents condition tolerates. These visits will be logged on the In Room One to One Program Sheet (see **Attachment B**) the day the visit is completed. **Corrective Action for Resident Potentially Affected:** All resident's requiring in room activities has the potential to be affected by the alleged deficient practice. All resident's requiring in room activities has been identified by completing an audit (see **Attachment C**). The Activities Director/Volunteer will visit with these resident's and provide 1:1 activities at least twice a week. These visits will be logged on the In Room One to One Program Sheet (see **Attachment B**) the day the visit is completed.	

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

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

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F 248	Continued From page 1 Review of the resident's activity log for January 2011 and February 2011 revealed the resident received 1:1 visits on January 4 for massage therapy and February 7 for a room visit. There were no other visits documented. During an interview with the activities director (AD) on 03/02/11 at 4:45 PM revealed she is unable to make 1:1 visits since her assistant was let go in December. She stated "I told the old (previous)administrator that this was going to happen." She indicated she was too busy to make sure Resident #43 is brought down for group singing activities, but she knows she (Resident #43) enjoys them. During an interview with the director of nursing (DON) on 03/02/11 at 5:15 PM revealed the administrator was responsible for the activities directors workload and responsibilities. The DON indicated her expectation would be that the activities director should have asked the nursing staff for help to make sure this resident got to the singing activities, as well as be taken out of her room when she is up in the chair for additional stimulation and activities. She indicated she would expect a resident who is cognitively impaired have at least a 1:1 visit done weekly. During an interview with the current Administrator on 03/02/11 at 6:00 PM revealed her expectation would be the activities director would make sure the residents receive the services they are entitled to and getting a cognitively impaired resident to activities is very important.	F 248	**Systemic Changes** The Activities Director was in-serviced on 3/17/11 by the Administrator on providing in room activities to residents that are unable to participate in out of room activities and logging these visits the day the visit occurred on the Activity Participation Record (see **Attachment D**) An in-service (see **Attachment E**) was conducted by the Staff Development Coordinator. Those who attended were all RN's and LPN's, CNA's and Med Techs, FT, PT, and PRN. The facility specific inservice was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care (see **Attachment F**). Any in-house staff member who did not receive in-service training by 3-31-11 will not be allowed to work until training has been completed. The in-service topics included: Activities and sensory stimulation. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Activities Director will monitor the Activity Participation Record using (QA Monitor for Resident Activities Being Met) (see **Attachment G**) for all residents requiring in room visits to ensure they received 1:1 activities twice a week. This will be completed weekly x 4 then monthly x 2 months or until resolved by the QA Team. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to trim and clean fingernails for 6 of 8 sampled residents who were dependent on staff. Residents (Resident # 104, # 149, #75, #115, #141, #86) Findings included: Record review of the facility policy titled " Nail, Care of (Finger and Toe), dated 10/1/01 read as follows: " Purpose 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems. 1. Resident # 104 was admitted to the facility on 3/18/10 with multiple diagnoses including dementia. The Minimum Data Set (MDS) dated 11/16/10 revealed Resident # 104 had short and long term memory impairment and need extensive assistance from nursing staff for activities of daily living (bathing, eating). Resident # 104 ' s care plan dated 1/6/11 revealed " Problem a " as " I can no longer take care of myself. " The " Goal: " was " Staff will anticipate and meet needs in a timely manner. " One of the " Approaches " listed	F 312	F 312 **Corrective Action for Resident Affected:** For Resident's #104, 149, 75, 115, 141 and 86, their nails were trimmed and cleaned 3/3/11. **Corrective Action for Resident Potentially Affected:** All resident's have the potential to be affected by the alleged deficient practice. An audit was completed of all residents assessing their nail care needs. Any residents identified as needing their nails trimmed and/or cleaned were given nail care. This was completed on 3/24/11. See **attachment H.** **Systemic Changes** An in-service was conducted by the Staff Development Coordinator (**see Attachment E**). Those who attended were all RN's and LPN's, CNA's and Med Tech's, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care (see **Attachment I**). Any in-house staff member who did not receive in-service training by 3-31-11 will not be allowed to work until training has been completed. The in-service topics included: Nail Care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 312	Continued From page 3 was " Help to bath, groom, and dress me each day and prn. " Record review of the nursing assistant (NA) care tracker dated 2/26/11 through 3/3/11 revealed no fingernail care completed during this period of time. On 03/01/2011 at 12:02 pm observations revealed black matter under all fingers nails on Resident # 104 while she was eating lunch with her fingers nails while eating lunch in the dining room. An interview with nursing assistant # 1 (NA) on 3/2/11 at 2:21 pm revealed she was responsible for the care of Resident # 104 on the 7:00 am - 3:00 pm shift on 3/2/11. She stated she cleans fingernails daily with bed bath or shower daily. NA # 1 stated she had completed all personal care for Resident # 104 for her shift on 3/2/11. On 3/2/11 at 4:17 pm Resident # 104 ' s fingers were observed with black matter under all fingernails. An interview with Nurse # 4 on 3/1/11 at 11:05 am revealed she expected NAs to cut and clean finger nails after a shower or bed bath daily. An interview with NA # 1 on 3/2/11 at 2:21 pm revealed she cleans the fingernails of all her assigned residents daily with the bed bath or shower. An interview with NA # 2 on 3/2/11 at 2:32 pm she revealed she included in her morning personal care by cleaning, filing and cutting resident fingernails daily.	F 312	**Quality Assurance** The Staff Development Coordinator will monitor this issue using the "Nail Audit QA Tool" for monitoring resident's nail care. The monitoring will look at the cleanliness and length of resident nails. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. **See attachment J.**	

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F 312	Continued From page 4 On 3/2/11 at 2:50 pm Nurse # 5 stated she expects all NA ' s to clean, cut and file resident fingernails daily. An interview was conducted with NA # 3 on 3/2/11 at 2:41 pm. She stated she cleaned and cut residents fingernails daily with a bed bath or a shower. On 3/4/11 at 10:25 am and interview with the Director of Nurses (DON) revealed she expected NA ' s to cut and clean fingernails with morning care every day. The DON stated she expects nurses on hall to be responsible for making sure fingernail care gets completed daily. An interview was conducted with the Administrator on 3/3/11 at 12:32 pm revealed she expected all Na's to cut and clean fingernails daily. 2. Record review of the facility policy titled " Nail, Care of (Finger and Toe), dated 10/1/01 read as follows: " Purpose 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems. Resident # 149 was admitted to the facility with diagnoses including osteoporosis and interstitial lung disease. The Minimum Data Set (MDS) dated 12/16/10 revealed Resident #149 had short and long term memory impairment and was totally dependent on nursing staff for activities of daily living.	F 312		

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F 312	Continued From page 5 Resident # 149 ' s care plan dated 6/16/10 revealed a " Problem " as " She requires extensive assist with ADL ' s (activities of daily living) r/t (related to) weakness, anxiety and pain. " The " Goal: " was " All care needs will be anticipated and met in timely manner " One of the " Approaches " listed was " Nail care on shower days and prn. " Record review of the nursing assistant (NA) care tracker dated 2/26/11 through 3/3/11 for Resident # 149 revealed the last entry for nail cleaning was 2/26/11. Observations on 3/1/11 at 10:25 AM revealed Resident # 149 had light brown matter under all her fingernails on her right hand. An interview with Nurse # 4 on 3/1/11 at 11:05 am revealed she expected NAs to cut and clean finger nails after a shower or bed bath. On 3/2/11 at 4:10 pm observations revealed Resident # 149 had light brown matter under the fingernails of her right hand. An interview with NA # 1 on 3/2/11 at 2:21 pm revealed she cleans fingernails of all her assigned residents daily with the bed bath or shower. An interview with NA # 2 on 3/2/11 at 2:32 pm she revealed she included in her am personal care by cleaning, filing and cutting resident nails daily. On 3/2/11 at 2:50 pm Nurse # 5 stated she expects all NA ' s to clean, cut and file resident fingernails daily.	F 312		

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F 312	Continued From page 6 An interview was conducted with NA # 3 on 3/2/11 at 2:41 pm. She stated she cleaned and cut residents fingernails daily with a bed bath or a shower. On 3/4/11 at 10:25 am and interview with the Director of Nurses (DON) revealed she expected NA ' s to cut and clean fingernails with morning care every day. The DON stated she expects nurses on hall to be responsible for making sure fingernail care gets completed daily. An interview was conducted with the Administrator on 3/3/11 at 12:32 pm revealed she expected all Na's to cut and clean fingernails daily. 3. Record review of the facility policy titled " Nail, Care of (Finger and Toe), dated 10/1/01 read as follows: " Purpose 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems. Resident # 75 was admitted to the facility on diagnosis of dementia. The Minimum Data Set (MDS) dated 1/31/11 revealed Resident # 75 had short and long term memory impairment and needed extensive assistance from nursing staff for activities of daily living. Resident # 75 ' s care plan dated 1/31/11 revealed a " Problem " as " I cannot care for myself. " The " Goal: " was " Staff will anticipate my needs in a timely manner. " One of the " Approaches " listed was " I need to be	F 312		

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F 312	Continued From page 7 bathed, dressed, and groomed by staff. " Record review of the nursing assistant (NA) care tracker dated 2/23/11 through 3/3/11 for Resident # 75 revealed there were no entries for nail care. On 3/2/11 at 11:52 am Resident # 75 was observed to have with jagged nail edges with brown matter noted under some of her finger nails. On 3/2/11 at 4:55 pm Resident #75 was observed to have jagged nail edges with brown matter under some of her fingernails. On 3/4/11 at 10:25 am and interview with the Director of Nurses (DON) revealed she expected NA ' s to cut and clean fingernails with morning care every day. The DON stated she expects nurses on hall to be responsible for making sure fingernail care gets completed daily. An interview was conducted with the Administrator on 3/3/11 at 12:32 pm revealed she expected all Na's to cut and clean fingernails daily. 4. Record review of the facility policy titled " Nail, Care of (Finger and Toe), dated 10/1/01 read as follows: " Purpose 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems. Resident # 115 was admitted to the facility on diagnoses CVA (cerebral vascular accident) with hemi paresis (muscle weakness affecting one	F 312		

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F 312	Continued From page 8 side of the body). The Minimum Data Set (MDS) dated 2/15/11 revealed Resident # 115 had short and long term memory impairment and needed extensive assistance from nursing staff for activities of daily living. Resident # 115 ' s care plan dated 2/15/11 revealed a " Problem " as " I need extensive assist with ADL ' s r/t left hemi pareses. " The " Goal: " was " I will continue to propel self short distances in w/c (wheel chair). " One of the " Approaches " listed was " Nail care on shower days and prn. " Record review of the nursing assistant (NA) care tracker dated 2/23/11 through 3/3/11 for Resident # 75 revealed there were no entries for nail care. On 03/02/11 at 10:15 am Resident # 77 was observed to have long jagged fingernails. On 03/03/11 at 12:24 pm Resident #77 was observed in the dinning room eating her lunch with long jagged finger nails. On 3/4/11 at 10:25 am and interview with the Director of Nurses (DON) revealed she expected NA ' s to cut and clean fingernails with morning care every day. The DON stated she expects nurses on hall to be responsible for making sure fingernail care gets completed daily. An interview was conducted with the Administrator on 3/3/11 at 12:32 pm revealed she expected all Na's to cut and clean fingernails daily. 5. Record review of the facility policy titled " Nail, Care of (Finger and Toe), dated 10/1/01 read as follows:	F 312		

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F 312	Continued From page 9 " Purpose 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems. Resident # 141 was admitted to the facility on diagnoses dementia, organic brain syndrome and CVA. The Minimum Data Set (MDS) dated 1/4/11 revealed Resident # 141 had short and long term memory impairment and needed extensive assistance from nursing staff for activities of daily living. Resident # 141 ' s care plan dated 4/21/10 revealed a " Problem " as " Relies on staff for care needs r/t cognition. " The " Goal: " was " All care needs will be anticipated and met in a timely manner. " One of the " Approaches " listed was " Nail care on shower days and prn. " Record review of the nursing assistant (NA) care tracker dated 2/25/11 through 3/3/11 for Resident # 75 revealed the last entry for nail care was 2/25/11. On 03/02/11 at 10:45 am Resident # 77 was observed to have dirty jagged finger nails. On 03/03/11 at 3:30 Pm Resident #77 was observed at sitting in a wheelchair at the nurses station with long, jagged, fingernails that were discolored and had brown matter under some of the nails. On 3/4/11 at 10:25 am and interview with the Director of Nurses (DON) revealed she expected NA ' s to cut and clean fingernails with morning care every day. The DON stated she expects nurses on hall to be responsible for making sure	F 312		

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F 312	Continued From page 10 fingernail care gets completed daily. An interview was conducted with the Administrator on 3/3/11 at 12:32 pm revealed she expected all Na's to cut and clean fingernails daily. 6. Record review of the facility policy titled " Nail, Care of (Finger and Toe), dated 10/1/01 read as follows: " Purpose 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems. Resident # 86 was admitted to the facility on diagnoses Alzheimer ' s dementia. The Minimum Data Set (MDS) 3.0 dated 1/26/11 revealed Resident # 86 had short and long term memory impairment and extensive assistance on nursing staff for activities of daily living. Resident # 86 ' s care plan dated 7/29/10 revealed a " Problem " as " Requires total assist for ADL ' s r/t cognition. " The " Goal: " was " All care needs will be anticipated and met in a timely manner. " One of the " Approaches " listed was " Nail care on shower days and prn. " Record review of the nursing assistant (NA) care tracker dated 2/26/11 through 3/3/11 for Resident # 86 revealed the last entry for nail care was 2/26/11. On 03/02/11 at 9:50 am Resident # 77 was observed to have irregular jagged fingernails. On 03/03/11 at 10:15 am Resident #77 was	F 312		

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F 312	Continued From page 11 observed in the day room sleeping in a wheelchair, her fingernails were noted to have jagged edges, irregular length and brown matter under some of them. On 3/4/11 at 10:25 am and interview with the Director of Nurses (DON) revealed she expected NA ' s to cut and clean fingernails with morning care every day. The DON stated she expects nurses on hall to be responsible for making sure fingernail care gets completed daily. An interview was conducted with the Administrator on 3/3/11 at 12:32 pm revealed she expected all Na's to cut and clean fingernails daily.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and nurse practitioner interviews and record reviews the facility failed to protect Resident#14 who required supervision from sustaining a first degree burn. The facility staff failed to implement the chair sensor alarm as noted in the plan of care. This was evident in 1 of 3 residents in the survey sample reviewed for accidents. Findings include:	F 323	F 323 **Corrective Action for Resident Affected:** Resident #14 was issued an adaptive cup with lid for drinking coffee on 3/3/11. Resident # 14 was issued a chair pad sensor alarm on 3/1/11. **Corrective Action for Resident Potentially Affected:** All resident's requiring supervision with their meals were identified and assessed for the need of an adaptive cup with lid for drinking coffee. Those residents that were assessed as needing an adaptive cup and lid were given their cups on 3/25/11 by the Dietary Manager. See **Attachment K.**	

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F 323	Continued From page 12 Resident #14 was admitted to the facility on 11/9/10 with diagnosis including diabetes mellitus and a fractured femur from a fall. Review of the Minimum Data Set (MDS) dated 02/3/11revealed Resident#14 was coded as being alert and cognitively impaired for decision making. Resident #14 required extensive assistance from the staff for all activities of daily living for mobility in the wheelchair and for transfers. The MDS also indicated that supervision from staff was required during meals. Review of the MDS dated 03/02/11 revealed hand tremors. Review of the physical therapy assessment dated March 2011 revealed hand tremors noted when the resident held a cup. The therapist recommended supervision when eating. Review of the resident ' s initial falls risk assessment dated 1/4/10 revealed a score of 6 out of 18, which indicated the resident was a low risk for falls. A falls risk assessment dated 01/05/11 revealed a score of 14 out of 18 which indicated the resident was at high risk for falls. Review of the falls log for this resident revealed documentation of falls on 11/2/10, 11/9/10 and 1/29/11. Review of the resident care plan dated 7/8/10 and revised 1/29/11 revealed an intervention for a chair alarm sensor and a Reacher for the resident to pick things up off the floor on 1/29/11. Observation on 03/01/11 at 10:40 AM of Resident #14 revealed she was sitting in her wheelchair without a chair alarm sensor. Resident#14 ' s left eye was ecchymotic (the purple or black-and-blue area resulting from a bruise) area. Her left eyelids and left upper	F 323	All residents requiring a chair pad sensor alarm have the potential to be affected by the alleged deficient practice. An audit was conducted to identify all residents that have a chair pad sensor alarm. Any residents noted without the chair pad sensor alarm was provided the alarm on 3/24/11. **See attachment L .** **Systemic Changes** An in-service was conducted on 3/3/11 by the Dietary Manager (**see Attachment M**). Those who attended were all dietary staff, FT, PT, and PRN. Any dietary staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: The importance of providing adaptive cups with lids for those identified residents when they are served coffee or other hot beverages. An in-service was conducted by the Staff Development Coordinator . Those who attended were all CNA's, RN's and LPN's, Med Tech's, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care . Any in-house staff member who did not receive in-service training by 3/31/11 will not be allowed to work until training has been completed. The in-service topics included: Reminding staff to provide oversight	

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F 323	Continued From page 13 cheek were swollen with a purple/ black-and-blue color. Interview with the resident during this observation revealed "I fell out of my chair last night." "I was bending down to pick something up off the floor and the chair kicked me out, I landed on the floor. " Front leg stabilizers were noted on the wheelchair. Observation of Resident#14 while sitting in her wheelchair on 3/2/11 at 4:10 PM revealed no chair alarm sensor on the resident ' s wheelchair. Review of the care tracker (documentation system used by the nursing assistants) (NA) dated from 02/01/11 to 03/02/11 revealed inconsistent documentation from the NA during this time frame. Several NA documented the chair pad was in place, several other NA documented both a chair alarm and bed alarm were in place, and then several other NA documented there were no devices in place for the resident. Review of the nurses notes revealed on 3/1/11at 8:00 AM " the resident spilled coffee on her lap at breakfast. A reddened area was noted on the R (right) upper thigh. On 3/2/11 at 5:15 PM the physician and LPN #1 were overheard speaking with Resident#14 and requesting to look at the burn on her right thigh. During an interview with LPN #1 on 03/02/11 at 5:35 PM indicated the resident spilled hot coffee on her lap yesterday morning. She further indicated she assessed the area and it was a reddened area the size of a small baseball, there was no blister noted. She called the doctor who ordered Silverdine cream to the area three times a day for 3 days. She also indicated the OT (occupational therapist) ordered a two handle cup to be used for all meals and to add ice to her hot beverages. Review of the evaluation by the OT dated	F 323	to all residents requiring supervision with meals. Also in-serviced was that all resident's requiring a chair pad sensor alarm will have that intervention fired to the PDA for the CNA's to document that it is in place. The chair pad sensor alarm will also be placed on the TAR for the nurses to check every shift for placement. The importance of making sure these interventions are in place was discussed as well. Also in-serviced was a falls intervention box will be placed at every nurses station (started 3/25/11) that will include different fall intervention items including chair pad sensor alarms. **(See Attachment E, N, O)** **Quality Assurance** The Dietary Manager will monitor this issue using the "Adaptive Cup with Lid+ QA Tool" **(see Attachment P)**. The monitoring will look at making sure residents have their adaptive cup and lid when hot beverages are served. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Staff development will monitor the placement of the chair pad sensor alarms by using the Chair Alarm QA Audit Tool **(see Attachment Q)**. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 323	Continued From page 14 03/02/11 revealed the resident had hand tremors and recommended the use of a two handled cup and adding ice to her coffee. An order was written for the cup to be implemented immediately and delivered to the dietary manager on 3/2/11 for the lunch meal. During an interview with the physical therapist (that did the resident ' s initial assessment in March 2011) on 03/02/11 at 6:10 PM revealed she was familiar with this resident since she has had therapy previously. She felt the use of a two handle cup would be very helpful since the resident had hand tremors. She indicated she placed an order for the two handle cup and handed it to the dietary manager yesterday afternoon. During an interview with the nurse practitioner on 03/02/11 at 6:20 PM revealed she was notified yesterday and she ordered Silverdine cream. After she evaluated the area this evening she felt it was a first degree burn and the Silverdine treatment was appropriate. During an observation of the resident in the dinning room for breakfast on 03/03/11 at 8:15 AM revealed the resident was served coffee in a one handled cup which was poured from the coffee carafe in the dinning room by NA #4. No ice was placed in the one handle cup before giving it to the resident. During an interview with NA #4 revealed she was not aware of the new order for the resident to have a two handled cup for hot beverages or that she was to add ice to the coffee before serving the resident. During an observation of the lunch cart in the dinning room on 03/03/11 at 12:15 PM with the dietary manager revealed Resident #14 ' s tray had a two handled cup on it. He stated " he is not sure why the resident did not have this two	F 323		

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F 323	Continued From page 15 handled cup on her tray this morning. " He also indicated the meal card now indicates to add ice to her hot beverages before serving them to the resident. " During an interview with the DON (director of nurses) on 03/03/11 at 9:40 PM revealed she was aware the resident was injured yesterday morning. She further indicated she would have expected the OT ' s recommendation of the use of a two handle cup and adding ice to her hot beverages would have been implemented this morning for breakfast. Review of the hospital discharge instructions dated 03/01/11 revealed documentation noted " you have been diagnosed with a facial contusion " the recommended treatment for contusion (bruise) consisted on gently applying ice to any areas of bruising or swelling. On 03/02/11 at 4:30 PM during an interview with the LPN #2 (who responded to the resident on 03/01/11) revealed he heard the roommate scream and he ran to the room. He stated " the resident was lying on the floor with her wheelchair behind her. She had fallen on her face and had a bruise noted to her left eye. We (several staff members) assisted the resident into the lift and returned her to bed. I assessed her and called the emergency transporters and she was taken to the hospital for evaluation. " He revealed he did not hear the chair alarm sound when the resident fell and he was not aware she had a chair alarm. He stated " I never saw one on her chair. " During an interview with LPN #1 (the daytime nurse) at 5:35PM revealed she was not aware the resident was supposed to have a chair alarm on her wheelchair. During an interview with NA #1 assigned to care	F 323		

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F 323	Continued From page 16 for resident on 03/02/11 at 11:15 AM, she revealed she noticed on 3/2/11 that Resident#14 ' s wheelchair was broken. NA#1 indicated a screw was missing on the wheelchair seat, so the maintenance man fixed it and also placed stabilizers on the front of the wheelchair so it could not tip over. NA#1 indicated on 3/1/11 there was no chair alarm sensor on Resident ' s 14 ' s wheelchair. NA #1 stated " I have not seen one (referring to the chair alarm sensor) on her chair. " During an interview with the maintenance man on 03/02/11 at 12:05 PM revealed the screw on the wheelchair seat must have fallen out. The maintenance man indicated he did install the stabilizers on Resident#14 ' s wheelchair to prevent her from tipping the wheelchair again. During an interview with the Director of Nursing (DON) on 3/2/11 at 11:30 AM revealed " I was aware of the resident ' s injury because she went to the hospital. " She also indicated the resident had an intervention for a chair alarm; it was added to the care plan and implemented when she fell in January 2011. She stated " we added the chair alarm after her fall in January. During an interview with the MDS Nurse on 3/2/11 at 4:15 PM revealed the care plan was updated and the care tracker was updated in January after she had fallen. A copy of the care tracker was provided for review. During an interview with LPN #1 on 03/02/11 at 11:30 AM, she stated " I was told she fell last night and was sent to the hospital, she was sent back to the facility last night. She indicated if a resident fell, you assess the resident for injury, administer first aid if necessary, call the family and then the doctor and follow the doctor ' s orders. I would have checked the wheelchair since she fell out of it, " I was told the	F 323		

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F 323	Continued From page 17 maintenance man put stabilizers on the front of the wheelchair this morning while he replaced the lost screw on the left back of the seat. " During an interview with the Administrator on 3/3/11 at 10:20 AM revealed her expectation was the staff would have implemented the recommendations for the resident yesterday for her lunch meal and she would have expected all staff that cared for this resident is aware of the new safety order.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain sanitary conditions in the kitchen by failing to keep cooking equipment (1 of 1 stove tops and 1 of 1 small ovens) cleaned. The facility also failed to store dry goods in a manner to protect from contamination by not sealing and/or dating (1 of 1 bags of elbow macaroni, 1 of 1 bags of egg noodles, 1 of 1 bags frozen chocolate chip cookie dough and 1 of 1 bags of frozen sugar cookie dough, and 1 of 1 bags of cake mix. Findings include:	F 371	F 371 **Corrective Action for Resident Affected:** The unsanitary conditions identified: stove top and small oven and the storage of dry goods was corrected on 3/3/11 by the Dietary Manager and District Manager by soaking the burners and cleaning the convection oven, sealing the dry goods and labeling these items. **Corrective Action for Resident Potentially Affected:** All resident's have the potential to be affected by the alleged deficient practice. An assessment was completed of the kitchen for unsanitary conditions on 3/3/11 by the Dietary Manager and District Manager. **See attachment R .**	

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F 371	Continued From page 18 Observations of the dry storage room on 2/28/11 at 5:15 pm revealed a 5 pound bag of white cake mix was unsealed. Further observations revealed 2 1/2 pound bag of elbow macaroni and 1/2 pound bag of egg noodles were unsealed and undated. The manager resealed the cake mix, macaroni and egg noodle bags and returned them to the dry storage shelf. On 2/28/11 at 5:46 pm observations of the freezer compartment revealed 1 bag frozen chocolate chip cookie dough (120 count) bag and 1 bag of frozen sugar cookie dough (150 count) were unsealed and undated. The manager resealed the two cookie dough bags and returned them to a shelf in the freezer. On 2/28/11 at 5:15 pm observations of stove equipment revealed 1/8 inch of heavy, greasy, crusted, black and brown matter on the surface of the stove including the gas flame wells. Further observations were conducted of the inside of a small oven. Inside the oven on the bottom left one-third of the surface had a heavy accumulation of brown and black matter. Observations of chocolate chip and sugar cookie dough bags on 3/2/11 at 11:15 am revealed a delivery dated of 2/16/11. The elbow macaroni and egg noodles had a delivery dated of 2/9/11. The cake mix had a handwritten date as delivered on 2/9/11. The 2 bags of cookie dough were sealed but remained undated. The manager stated it was his " expectation that all items are dated and resealed when opened by kitchen staff. " On 3/2/11 at 11:18 am observations of the dry storage room was conducted. Observations	F 371	**Systemic Changes** An in-service was conducted on 3/3/11 by the Dietary Manager (**see Attachment S**) Those who attended were all dietary staff, FT, PT, and PRN. Any dietary staff member who did not receive in-service training by 3/31/11 will not be allowed to work until training has been completed. The in-service topics included: proper food storage and maintaining cleanliness of the kitchen equipment including the stove top and small oven. Daily and weekly cleaning schedules were put in place and in-serviced on. **See attachments T and U.** **Quality Assurance** The Dietary Manager will monitor this issue using the "Weekly Cleaning QA Tool" (see **Attachment V**) and "Food Storage QA Tool (see **Attachment W**) This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 371	Continued From page 19 revealed a 5 pound bag of white cake mix was sealed but remained undated. Further observations revealed 2 1/2 pound bag of elbow macaroni and 1/2 pound of egg noodles were sealed but undated. An interview on 3/2/11 at 4:10 pm revealed the manager would keep elbow macaroni and egg noodles and cake mix after they are opened 5 -7 days and frozen cookie dough that had been resealed and dated was kept for 2 weeks. The kitchen manager stated, " I will throw out the elbow macaroni, egg noodles, cake mix and frozen cookie dough. " Observations on 3/1/11 at 4:25 pm revealed 1/8 inch of heavy, greasy, crusted, black and brown matter on the surface of the stove including the gas flame wells. Inside the small oven on the bottom left one-third of the surface had an accccumulation of brown and black matter. An interview with the kitchen manager on 3/2/11 at 11:05 am revealed the kitchen staff had "cleaned the small oven last night, because it was a little dirty." The manager stated, "This task is assigned to Cook # 1 who cleans it "when she finds time to clean it once a week. " The manager stated he expected the oven to be cleaned weekly. Observations on 3/2/11 at 11:05 am revealed the inside of the small oven was clean. On 3/2/11 at 11:15 am observations of the stove top revealed 1/8 inch of greasy, crusted black and brown matter on surface of the stove and the gas flame wells.	F 371		

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F 371	Continued From page 20 An interview was conducted with Cook # 1 on 3/2/11 at 11:20 am. She revealed, " I cleaned the stove last Friday by using oven cleaner and soaking the stove top sections. The cook stated the stove top "gets dirty easily." An interview with the kitchen manager on 3/2/11 at 11:31 am revealed he did not keep a log of weekly kitchen duties with their completion dates. He stated he did have a deep cleaning assignment list with weekly kitchen assignments for kitchen staff members. The kitchen manager stated each staff member informs him when they complete their deep cleaning task for the week. The manager stated if a kitchen employee was sick or out on vacation, " I complete their deep cleaning assignment myself. " On 3/2/11 at 11:32 am observations were made of The " Deep Cleaning List " posted in the kitchen. The list had employees names and their assigned deep cleaning task nest to their name. At the bottom of the list there were instructions that read, " All Tasks Must Be Completed On A Weekly Basis. Check with manager upon completion! " Observations of Cook # 1 revealed she was cleaning the stove top parts in a sink on 3/2/11 at 4:05 pm. The soapy water was black. An interview with the Administrator at 3/3/11 at 4:07 pm revealed she expected kitchen staff to seal and date all food items. She also expected the stove and oven to be clean at all times.	F 371		