STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345249	A. BUILDING _____ B. WING _____ MAY 24 2011	04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOREHEAD NURSING CENTER	205 EAST KINGS HWY EDEN, NC 27288

(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 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure that the surety bond had adequate coverage for resident accounts for 1 of 1 surety bond. The findings include: A review of the surety bond for the resident accounts dated 9/8/10 revealed it was limited at 25,000 dollars ($). A review of the resident accounts for the month of January, February, and March revealed the facilities accounts were over $25,000. In January, the resident accounts balance closed at $34,966.79, February account closed at $40,570.78, and in March the facility accounts generated $44,075.01. On 4/28/11 at 11:02 am, the office manager revealed there were fewer accounts in December, but in January there was an increase in resident accounts. The office manager stated the accounts doubled. On 4/28/11 at 11:20 am, the administrator revealed he was in charge of the surety bond. The administrator stated the office manager,	F 161	1.A new surety bond was requested and obtained, increasing amount from $25,000 to $50,000. 2.An audit of the current balance of trust funds was reviewed and the highest average balances were noted. The highest balance of $22,000 was under the current bond limit 3.When the resident fund reconciliation is completed at least quarterly, the fund balance will be noted to ensure it does not exceed the surety bond balance. If it does exceed the amount, a change in the surety bond amount will be requested. A meeting was held 5-18-2011 to discuss the above procedure. In attendance were; Administrator, Business Office staff, and Hospital financial staff 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, DON, Medicaid Directors, Pharmacist, members of the management team and others as needed	5/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barry J. Williams	Administrator	5-20-2011

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 161	Continued From page 1 hospital personnel, and himself were monitoring the resident accounts. The administrator was not aware of the increase in resident accounts. The administrator stated all parties involved in the resident accounts needed to communicate to each other about the resident's accounts. The administrator stated the surety bond needed to be increased due to resident accounts balances.	F 161		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to provide a catheter bag cover for one (1) of two (2) sampled residents with an indwelling catheter (Resident # 19). Findings included: Resident #19 was originally admitted to the facility 09/04/2009 and readmitted to the facility on 04/11/2011. Cumulative diagnoses included: history of urinary tract infection and urinary retention. Significant change Minimum Data Set (MDS) dated 02/22/2011 stated Resident #19 displayed no short term or long term memory impairment and was independent in decision-making. The assessment indicated Resident #19 had an indwelling catheter.	F 241	1.The resident identified without a catheter bag was provided a catheter bag cover. The identified resident assessment and care plan were reviewed and updates made as necessary. 2.An audit of all residents with catheters was done to ensure each had appropriate documentation for the catheter and each resident with a catheter is provided a cover for the bag. Random audits are being done weekly and prn by daytime RN supervisors to ensure dignity bags are in place. Appropriate actions to be taken if dignity bags not in place, up to and including disciplinary actions for repeat deficient practices. 3.An in-service was conducted on 5/19/11 and 5/20/11 covering F241-Dignity and respect of individuality with emphasis on foley catheters and dignity bags. The therapy staff was provided copies of the appropriate policy outlining the use of catheter bag covers.	5/26/11

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F 241	Continued From page 2 Care plan dated 09/06/2009 and updated 12/02/2010 stated Resident #19 had an indwelling catheter due to urinary retention. Approaches included: catheter care per facility policy. On 04/26/2011 at 2:10 PM., Resident #19 was observed in the hallway of the facility with physical therapy staff in attendance. She was sitting in a wheelchair with the catheter drainage bag hanging underneath the chair. The drainage bag was not covered. On 04/26/2011 at 2:10 PM., the physical therapy assistant stated therapy staff placed the catheter bag under her wheelchair and Resident #19 did not want a privacy bag covering her catheter bag. On 04/27/2011 at 3:30 PM., Resident #19 was observed in her room. Her urinary drainage bag was inside a privacy bag. On 04/27/2011 at 3:30 PM., Resident #19 stated she had never said she did not want a privacy bag. She liked the bag because it gave her more privacy. On 04/28/2011 at 9:20 AM., nursing assistant (NA) #1 stated Resident #19 had an indwelling catheter since admission. Nursing staff had tried to use a privacy bag but Resident #19 tended to use the bag as a pocketbook. NA #1 stated Resident #19 liked to move the catheter bag around and removed it from the privacy bag. NA #1 stated she had given Resident #19 a bath that morning and the drainage bag was not in the privacy bag at that time.	F 241	4.The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed	

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F 241	Continued From page 3 On 04/28/2011 at 1:45 PM., Resident #19 stated it was very important to her to "not let everything shine" and she wanted the urinary drainage bag covered. On 04/28/2011 at 5:50 PM., the Director of Nursing stated she expected the urinary drainage bags to be covered in a privacy bag	F 241		
F 276 SS=C	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with facility staff, the facility failed to prepare quarterly assessments in 92 days for 7 of 24 sampled residents. (Residents #1, #3, #5, #7, #9, #11 and #26). The findings include: 1. Resident #1 was admitted to the facility on 10/24/09. Record review revealed that her last MDS (Minimum Data Set) was an Annual dated 9/24/10. There was no MDS completed for the month of December, 2010 or the month of March, 2011. On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the other nurse was	F 276	1.Quarterly assessments for residents # 1, 3, 5, 7, 9, 11, and 26 were completed and transmitted. 2.An audit of all assessments, by type, was conducted. Late or incomplete assessments were completed or corrected as needed and transmitted. 3.A plan for completion of assessment and a 90 day calendar was developed and implemented. The plan and calendar is monitored daily during facility morning meeting. We are actively recruiting for a full time MDS staff member. Temporary agency use continues as needed. 4.The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, DON, Medicaid Directors, Pharmacist, members of the management team and others as needed	5/26/11

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F 276	Continued From page 4 out on leave. Nurse #1 stated she had informed her supervisor about being short staff for MDS's. The nurse stated the facility hired outside assistance, but MDS's were still behind. On 4/28/11 at 5:15 pm, Nurse #2 revealed she was aware of the MDS's not being caught up. The nurse was unaware of how far behind the staff was on MDS's. The nurse stated the facility hired outside assistance. Nurse #2 stated the MDS's were still behind even though there was assistance from another agency. On 4/28/11 at 5:25 pm, the Director of Nursing (DON) revealed the facility was aware of the issues with the MDS's before survey team entered the building, but there was not enough time to go over all of the MDS's. 2. Resident #3 was admitted to the facility on 7/30/10. The initial MDS (Minimum Data Set) was an Initial and was dated 8/10/10. The next MDS was a Quarterly dated 4/19/11; however, it was not filled out. It was blank in the computer. The MDS had the residents name and date only on the MDS. On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the other nurse was out on leave. Nurse #1 stated she had informed her supervisor about being short staff for MDS's. The nurse stated the facility hired outside assistance, but MDS's were still behind. On 4/28/11 at 5:15 pm, Nurse #2 revealed she was aware of the MDS's not being caught up. The nurse was unaware of how far behind the staff	F 276		

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F 276	Continued From page 5 was on MDS's. The nurse stated the facility hired outside assistance. Nurse #2 stated the MDS's were still behind even though there was assistance from another agency. On 4/28/11 at 5:25 pm, the Director of Nursing (DON) revealed the facility was aware of the issues with the MDS's before survey team entered the building, but there was not enough time to go over all of the MDS's. 3. Resident #5 was admitted to the facility on 2/17/09. The resident's clinical record was reviewed, including the Minimum Data Set (MDS). The computer files revealed a quarterly MDS was completed with an Assessment Reference Date (ARD) of 10/18/11. Following the quarterly MDS was an annual assessment with the ARD of 1/14/11. There had been no entry following the 1/14/11 MDS. During an interview on 4/28/11 at 3:12 PM, Nurse #1, who worked in the MDS office, stated that she was aware the MDS staff were behind on completing assessments. She stated that they had started getting behind when two MDS staff members had been out for extended medical leave. She stated the Administrator had been made aware that the MDS assessments were not being completed in a timely manner as early as March 2011. She stated she had told him that they (MDS staff) could not get the assessments caught up. She stated that the MDS staff used a Care Plan list compiled from the Medical Records	F 276		

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F 276	Continued From page 6 office to determine who needed to have an assessment completed. She stated that the facility had hired help from an outside agency to help with MDS completion. The agency nurse had not been successful in assisting staff to catch up overdue MDSs. At 3:55 PM on 4/28/11, Nurse #2 was interviewed. She stated that she had been pulled to help the MDS staff catch up on MDS assessments. She stated she did not know how far behind they were in completing assessments. She stated she had talked to the Administrator concerning overdue MDS assessments. The Director of Nursing (DON) and Interim DON were interviewed on 4/28/11 at 4:46 PM. The DON stated that it had started coming to light that there was an issue, but she was unaware of the magnitude of the problem prior to the survey. The Interim DON stated the MDS staff had let her know they were behind, but she was unaware of how far behind that they were until the survey. 4. Resident #7 was admitted on 4/14/06 and had been re-admitted on 8/31/10. The resident's clinical record was reviewed, including the Minimum Data Set (MDS). The computer files revealed an annual MDS was completed with an Assessment Reference Date (ARD) of 12/27/10. Although a quarterly assessment was overdue, no MDS had been initiated in the computer system. During an interview on 4/28/11 at 3:12 PM, Nurse #1, who worked in the MDS office, stated that she was aware the MDS staff were behind on	F 276		

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F 276	Continued From page 7 completing assessments. She stated that they had started getting behind when two MDS staff members had been out for extended medical leave. She stated the Administrator had been made aware that the MDS assessments were not being completed in a timely manner as early as March 2011. She stated she had told him that they (MDS staff) could not get the assessments caught up. She stated that the MDS staff used a Care Plan list compiled from the Medical Records office to determine who needed to have an assessment completed. She stated that the facility had hired help from an outside agency to help with MDS completion. The agency nurse had not been successful in assisting staff to catch up overdue MDSs. At 3:55 PM on 4/28/11, Nurse #2 was interviewed. She stated that she had been pulled to help the MDS staff catch up on MDS assessments. She stated she did not know how far behind they were in completing assessments. She stated she had talked to the Administrator concerning overdue MDS assessments. The Director of Nursing (DON) and Interim DON were interviewed on 4/28/11 at 4:46 PM. The DON stated that it had started coming to light that there was an issue, but she was unaware of the magnitude of the problem prior to the survey. The Interim DON stated the MDS staff had let her know they were behind, but she was unaware of how far behind that they were until the survey. 5. Resident #9 was originally admitted to the facility on 10/1/10, but was readmitted on 1/4/11. Resident #9's admission Minimum Data Set	F 276		

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F 276	Continued From page 8 (MDS) was completed on 1/8/11. A review of Resident #9's most recent quarterly MDS was dated 1/8/11. The facility was unable to provide a quarterly assessment for April 2011. On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the MDS nurse was out on leave. Nurse #1 had been out on leave as well from November 2010 to February 2011. Nurse #1 stated she had informed her supervisor about being short staff for MDS's. The nurse stated the facility hired outside assistance, but MDS's were still behind. On 4/28/11 at 5:15 pm, Nurse #2 revealed she was aware of the MDS's not being caught up. The nurse was unaware of how far behind the staff was on MDS's. Nurse #2 was part-time. The nurse stated the facility hired outside assistance. Nurse #2 stated the MDS's were still behind even though there was assistance from another agency. The nurse was not trained on updated MDS version 3.0. On 4/28/11 at 5:25 pm, the Director of Nursing (DON) revealed the facility was aware of the issues with the MDS's before survey team entered the building, but there was not enough time to go over all of the MDS's. 6. Resident #23 was admitted to the facility on 6/16/05. Resident #23 annual MDS was completed on 12/31/10. A review of Resident #23's most recent quarterly Minimum Data Set (MDS) was dated 12/31/10.	F 276		

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F 276	Continued From page 9 The facility was unable to provide a quarterly assessment from March 2011. On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the MDS nurse was out on leave. Nurse #1 had been out on leave as well from November 2010 to February 2011. Nurse #1 stated she had informed her supervisor about being short staff for MDS's. The nurse stated the facility hired outside assistance, but MDS's were still behind. On 4/28/11 at 5:15 pm, Nurse #2 revealed she was aware of the MDS's not being caught up. The nurse was unaware of how far behind the staff was on MDS's. Nurse #2 was part time. The nurse stated the facility hired outside assistance. Nurse #2 stated the MDS's were still behind even though there was assistance from another agency. The nurse was not trained on updated MDS version 3.0. On 4/28/11 at 5:25 pm, the Director of Nursing (DON) revealed the facility was aware of the issues with the MDS's before survey team entered the building, but there was not enough time to go over all of the MDS's. 7. Resident # 11 was admitted to the facility on 11/17/06. Resident #11 annual MDS was completed on 8/31/10. A review of Resident #11's most recent quarterly Minimum Data Set (MDS) was dated 1/23/11. The facility was unable to provide a quarterly assessment for April 2011.	F 276		

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F 276	Continued From page 10 On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the MDS nurse was out on leave. Nurse #1 had been out on leave as well from November 2010 to February 2011. Nurse #1 stated she had informed her supervisor about being short staff for MDS's. The nurse stated the facility hired outside assistance, but MDS's were still behind. On 4/28/11 at 5:15 pm, Nurse #2 revealed she was aware of the MDS's not being caught up. The nurse was unaware of how far behind the staff was on MDS's. Nurse #2 was part time. The nurse stated the facility hired outside assistance. Nurse #2 stated the MDS's were still behind even though there was assistance from another agency. The nurse was not trained on updated MDS version 3.0. On 4/28/11 at 5:25 pm, the Director of Nursing (DON) revealed the facility was aware of the issues with the MDS's before survey team entered the building, but there was not enough time to go over all of the MDS's.	F 276		
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

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F 280	Continued From page 11 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to develop an individualized care plan for one(1) of twenty four (24) residents (Resident # 12) and failed to review and revise a care plan for two (2) of twenty-four (24) residents (Resident # 14, Resident #19). Resident #12 had an admission care plan but the facility did not follow through with an individualized care plan. Care plan for Resident #14 was not revised when restorative nursing was discontinued on 03/21/2011. Care plan for Resident #19 was not reviewed and updated following hospitalization for left femoral fracture on 03/12/2011 and hospitalization for surgery for left femoral fracture on 04/08/2011. Findings included: 1. Resident #12 was admitted to the facility on 03/19/2011. Cumulative diagnoses included: left hip fracture, Dementia, Diabetes, Gastroesophageal reflux disease (GERD) and iron deficiency. A comprehensive minimum data set (MDS) had not been completed by the facility.	F 280	1.The care plans for the residents #12 and 19 were developed and updated as appropriate. 2.An audit of all resident's care plans was, completed, updating as appropriate. 3. Additional trained staff were contracted from an agency to assist with assessment completion. The procedure for assessment completion was reviewed and all appropriate staff instructed. A calendar of completion by day was developed for May, June, and July. A plan was developed to identify all incomplete or late assessments showing tasks by discipline and a time line for completion was put in place. Recruitment efforts to fill a newly created position including the use of a contract recruiter continue. 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed.	5/26/11

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

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(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 280	Continued From page 12 Admission care plan dated 03/18/2011 stated Resident #12 required limited to extensive assistance with activities of daily living and potential for weight loss related to leaving 25% or more of food uneaten at most meals. Potential for skin breakdown was not addressed on the care plan. On 4/26/2011, observations throughout the day revealed Resident #12 received total care by nursing staff. On 04/27/2011 at 9:10 AM., Nursing assistant (NA) #1 stated Resident #12 required total assistance with all areas of her care. On 4/27/2011 at 10:00 AM., Nurse #3 stated Resident #12 developed an unstageable pressure ulcer on 04/12/2011. Wound care treatment and air boots for both feet were implemented on 04/12/2011. On 04/28/2011 at 3:10 PM., Nurse #1 (MDS nurse) stated the MDS's were behind. Nurse #1 stated the initial care plan is generated after the MDS is completed. She could not generate an initial care plan because she was a licensed practical nurse (LPN). Nurse #1 stated she had been out on leave from November until February, then the full time MDS coordinator (RN) had been out on leave. Nurse #1 stated Resident #12 should have been care planned by now. On 04/28/2011 at 5:00 PM., the Director of Nursing stated there had been a lot of staffing issues with the MDS department (staff being part-time, MDS co-coordinator (RN) being out on	F 280		

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	345249	A. BUILDING _____ B. WING _____	04/28/2011

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F 280	Continued From page 13 leave). When asked regarding care plans (initial, updating of the care plans), she stated she expected the care plans to be completed, updated episodically and, at a minimum, reviewed quarterly. 2. Resident #19 was originally admitted to the facility 09/04/2009 and readmitted to the facility on 04/11/2011. Cumulative diagnoses included: arthritis, congestive heart failure, left femoral fracture 03/12/2011, history of urinary tract infection and urinary retention. Significant change Minimum Data Set (MDS) dated 02/22/2011 stated Resident #19 displayed no short term or long term memory impairment and was independent in decision-making. She required supervision with transfers, dressing, eating, personal hygiene and bathing. She was independent with ambulation in her room and in the hallway. Medical record was reviewed. The Care plan available to nursing staff was dated 09/06/2009 and updated 12/8/2010. Care Plan stated Resident #19 was at risk for falls due to history of falls with her last fall 08/24/2010. Approaches included non-skid shoes/ socks when out of bed, assist with toileting as needed, and provide walker for use when ambulating resident. Medical record review revealed Resident #19 sustained a left femoral fracture on 03/12/2011 and was hospitalized 03/12/2011-03/15/2011. Resident #19 was also hospitalized 04/08/2011-04/11/2011 for surgery for the left femoral fracture.	F 280		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 14 On 04/28/2011 at 1:45 PM., Resident #19 stated nursing staff assisted with bathing, dressing, getting out of bed and toileting. Resident #19 stated she could not walk by herself, received physical therapy and walked twenty-two steps with them on 04/27/2011. On 04/28/2011 at 2:00 PM., Nurse #1 provided a care plan with risk for falls due to history of falls reviewed and updated 04/04/2011. Approaches included: provide walker for use when ambulating resident, no weight bearing on left leg. On 04/28/2011 at 3:10 PM., Nurse #1 stated she had been out on leave from November until February and then the full time MDS coordinator (RN) had been out on leave. Nurse #1 stated Resident #19 should have had a revised care plan within fourteen days of the significant change assessment dated 02/22/2011. She did not know why a revised care plan had not been completed and placed in the medical record. On 04/28/2011 at 5:00 PM., the Director of Nursing stated there had been a lot of staffing issues with the MDS department (staff being part-time, MDS coordinator (RN) being out on leave). When asked regarding care plans (initial, updating of the care plans), she stated she expected the care plans to be completed, updated episodically and, at a minimum, reviewed quarterly. 3. Resident #14 was admitted to the facility 06/30/2009. Cumulative diagnoses included: history of right hip and right elbow fracture, myalgia, myositis, and chronic obstructive pulmonary disease.	F 280		

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F 280	Continued From page 15 Annual minimum date set dated 02/07/2011 stated Resident #14 was cognitively intact. She was independent with transfers and toileting, required supervision with bed mobility, ambulation in the hallway, personal hygiene and bathing. Balance was unsteady during transitions and walking. Range of motion was limited in both upper and lower extremities. Care plan dated 02/16/2011 indicated Resident #14 had impaired mobility due to weakness. Restorative program was in progress. Approaches included: Restorative ambulation with contact guard assistant and wheeled walker up to 250 feet and assisted range of motion to both lower extremities using two pound weights. On 04/28/2011 at 11:55 AM., Nurse #3 (restorative nurse) stated Resident #14 had complained that ambulation using the walker had bothered her shoulder. She was discharged from restorative nursing on 03/21/2011 and she should have discontinued restorative nursing on the care plan. On 04/28/2011 at 5:00 PM., the Director of Nursing stated she expected the care plans to be completed, updated episodically and, at a minimum, reviewed quarterly. \resident care plans should be current and up to date.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to transcribe physician orders to the medication administration record for 1 of 26 sampled residents (resident #25) whose medication orders were reviewed, and failed to follow the physician's order for weekly weights for 1 of 26 sampled residents (resident #10). Findings include: 1. Resident #25 was admitted to the facility on 4/20/11 with multiple diagnoses including congestive heart disease, hypertension, and coronary artery disease. Record review of the resident's clinical record revealed physician orders dated 4/20/11 for Isosorbide 40mg (milligram) daily. Isosorbide is a vasodilator used for the treatment of congestive heart failure and angina. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions, stated in part: "abrupt withdrawal may result in angina." Reconciliation of medication orders after a medication pass observation on 4/27/11 at 8:25AM revealed the resident's Isosorbide was not given. Review of the resident's medication administration record (MAR) revealed no entry for Isosorbide 40mg daily. In an interview on 4/27/11 at 9:30AM, Nurse #4 examined the resident's physician order sheet and MAR and acknowledged the Isosorbide order was not on the MAR. Nurse #4 stated the order must not have been transcribed to the MAR at admission and had not been given. He stated the	F 281	1.The physician orders for residents # 10 and 25 that were not transcribed to the medication administration record were corrected. 2.All physician orders were checked for accuracy in transcription. Random audits of physician orders will be done weekly to identify any areas of concern. All identified issues will be resolved as needed. 3.In-services training was conducted to review the physician order transcription process. Training will be provided to all newly hired nurses as well as any nurses identified as needing the training. Random audits of physician order transcription will be conducted and corrective action taken as needed. 4.The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, DON, Medicaid Directors, Pharmacist, members of the management team and others as needed	5/26/11

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F 281	Continued From page 17 facility printed the physician order sheets and MARS. He stated the admitting nurse would have been responsible for transcribing orders from the physician order sheet to the MAR. Nurse #4 stated he would add the order to the MAR and begin administration of the medication immediately. Inspection of the medication cart revealed the pharmacy had dispensed 15 tablets of Isosorbide on 4/20/11. In an interview on 4/28/11 at 4:09 PM, the Director of Nursing (DON) stated for new admissions, the nurse assigned to that resident reviewed admission orders and entered them into the computer to generate the MAR. She stated the nursing staff administered medications according to the MARS. The DON stated there was not currently a system in place to double-check the MARS for new admissions and added "there will be from now on." The DON stated she expected the staff to transcribe all medication orders accurately to the MARS. The nurse responsible for transcribing the Isosorbide order to the resident's MAR was not available for interview. 2. Resident #10 was originally admitted to the facility on 11/11/05, but was readmitted on 3/21/11 with a diagnosis of Alzheimer Disease. Resident # 10's Minimum Data Set (MDS) was not updated for cognitive status. The physician ' s order in April 2011 for Resident #10 revealed the resident was to be weighed for 4 weeks upon readmission on 3/21/11. The resident's Medication Administration Records	F 281		

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F 281	Continued From page 18 (MAR's) for the month of April 2011 revealed Resident #10 would be weighed weekly for 4 weeks upon readmission on 3/21/11." Resident #10 was supposed to be weighed on 4/4/11, 4/11/11, 4/18/11, and 4/25/11. There were no weights completed on those days. Resident's #10 ' s Care Plan (CP) dated 3/21/11 revealed "weigh weekly for 4 weeks." Resident #10's Weight sheet revealed the last two weights were on 3/9/11 and 4/16/11.There were no other weights recorded. On 4/28/11 at 2:07pm, the NA #1 stated she did not weigh Resident #10 for 4 weeks. The NA revealed the resident was in a lot of pain and refused to be weighed. On 4/28/11 at 2:12pm, Nurse # 8 revealed Resident#10 had not been weighed for 4 weeks. The nurse stated she was never informed that Resident#10 refused to be weighed. The nurse revealed if a resident refused to have their weight taken, NA was to inform the nurse, the nurse would attempt to weigh the resident, but if the nurse was unsuccessful the nurse would report to the next shift and the next shift would attempt to weigh the resident. Nurse# 8 revealed weekly weights were completed on Monday ' s. On 4/27/11 at 9:26am, the Dietary Manager (DM) provided documentation about Resident #10 weights. The DM revealed 3/21/11 and 4/16/11 were the only weights provided to her from the staff. The DM revealed the Nursing Assistant (NA) was responsible for weighing the residents.	F 281		

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F 281	Continued From page 19 On 4/28/ 11 at 2:30pm, Nurse # 4 revealed Resident #10 never refused care or weights. Nurse# 4 also revealed NA ' s never reported Resident #10 refusing care or being weighed. Nurse # 4 worked with Resident #10 on 4/4/11 and was not informed about refusal of care. On 4/28/11 at 5:25pm, the Director of Nursing (DON) revealed residents ' should be weighed for 4 weeks upon admission and readmission as documented on the MAR per facilities policy. The DON stated there were spaces on the MAR for staff to sign off after the resident was weighed. The DON stated the weekly weights should be on the MAR so that the nurses could remind the NA's to weigh the resident's on Monday.	F 281		
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure fifteen (15) months of the Minimum Data Set (MDS) which were maintained electronically were accessible to staff. The findings include: During the entrance conference of the survey on 4/26/11 at 8:05, the Nurse #1 stated that all MDS assessments and care plans were in a folder in a filing cabinet at each nursing station for all residents.	F 286	1.All professional nurses were given access to the computer application to allow them access to the MDS. Instructions were provided to all nurses Via e-mail on 5/20/2011. 2.An audit of all current nurses access status and skills level was conducted 4/26/11. 3. A procedure was developed to ensure all existing nursing staff and new staff receive training on how to access the appropriate application to allow access to resident assessments. A list of all the nurses and their access status will be maintained by the Director of Nurses.	5/26/11

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F 286	Continued From page 20 On 4/27/11 at 2:48 PM, the Director of Nursing (DON), and the Interim DON stated that all MDS 3.0 assessments were filed electronically. The DON stated that all nurses had access. The DON asked a nurse who was at the nursing station on the south hall to go into the computer and access the MDS for a resident who resided on that hall. The nurse attempted to log in and was denied access. The DON asked the Medical Records Clerk to determine who had access and who needed access. The Medical Records Clerk was interviewed on 4/28/11 at 10:47 AM. She stated that during the upgrade from MDS 2.0 to MDS 3.0, the facility computer system had been updated. During the update, staff access had been changed. This change resulted in some nurses being denied access. She stated that she was unaware of specific staff that were unable to access MDS data. She stated nurses were listed in groups and some groups were not given access to MDS data after the updates for MDS 3.0. All groups of nurses had been updated to have access to MDS data. The DON stated in an interview on 4/28/11 at 5:20 PM that all nurses now had access to the MDS data.	F 286	4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administrator, Director of Nurses, Medical Directors, Pharmacist, members of the management team and others as needed.	
F 287 SS=B	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment.	F 287		

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F 287	Continued From page 21 (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the	F 287	1.The assessments for residents # 10, 11, 12, 19 were completed and transmitted. 5/26/11 2.An audit of assessments of all types was completed showing resident, type of assessment, and date was completed. Two additional staff from a personnel staffing service were retained to assist with completion of assessments. 3.A procedure and 90 day calendar system for completion and transmission of assessments was developed and implemented. Calendars were distributed to all Interdisciplinary Team Members and it will be a standing agenda item for facility morning meeting. We are actively recruiting for a full time MDS staff member and will continue to use temporary agency staff as needed. 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed.	

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F 287	Continued From page 22 format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to transmit completed assessments in a timely manner for four (4) of twenty-four (24) residents (Resident #10, Resident #11, Resident #12, Resident #19). Findings included: 1. Resident #12 was admitted to the facility on 03/19/2011. Cumulative diagnoses included: left hip fracture, Dementia, Diabetes, Gastroesophageal reflux disease (GERD) and iron deficiency. Medical record was reviewed. A fourteen day comprehensive assessment using the Minimum Data Set (MDS) was not in the medical record. On 04/26/2011 at 10:55 AM., a request was made to the MDS nurse for the admission assessment for Resident #12. Nurse #1 stated there were no Minimum Data Set assessments done for Resident #12. She stated they knew they were behind with MDS's but they were not sure how far behind. She stated she had been out on medical leave from November 2010 until February 2010. The MDS coordinator was out on leave in February, returned in March 2011 and went out on leave at the end of March 2011. Nurse #1 stated she could not complete the MDS because she was a licensed practical nurse (LPN). On 04/27/2011 at 11:00 AM., the Director of	F 287		

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F 287	Continued From page 23 Nursing stated MDS's should be completed and transmitted within the time frame required. On 04/28/2011 at 3:10 PM., Nurse #1 stated she did not have any idea how many MDS's were behind. She knew there were some that needed to be done for the month of March-maybe twenty-five (25)--thirty(30) or more. On 04/28/2011at 3:55 PM., Nurse #2 (MDS RN) stated she worked part time and averaged one to two twelve hours day per week working with the MDS's. Nurse #2 stated she had not been to any classes or obtained training with MDS 3.0. She stated she had discussed with administration how far behind they were with MDS's and that they needed help. Nurse #2 stated she had transmitted 52 records today. She did not know how many MDS's were delinquent. 2. Resident #19 was admitted to the facility 09/04/2009. She was hospitalized 03/12/2011-03/15/2011 for a left femoral fracture and hospitalized 04/08/2011-04/11/2011 for surgery for the left femoral fracture. On 04/26/2011, Resident #19's Minimum Data Set assessments were reviewed electronically. Last assessment was a significant change assessment dated 02/22/2011. The assessment had not been completed and transmitted at that time. On 04/27/2011 at 11:00 AM., the Director of Nursing stated MDS's should be completed and transmitted within the time frame required. On 04/28/2011 at 2:00 PM., significant change	F 287		

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F 287	Continued From page 24 assessment dated 02/22/2011 was completed. Signatures of staff that had completed the assessment areas were as follows: Social worker (sections D,E,J,Q) 03/21/2011, Dietary (section K) 03/21/2011, Activities (section C,F) 03/25/2011, Registered Nurse (section M) 04/08/2011 and Registered Nurse (sections A,B,G,H,I,L,N,O,P,V,X,Z) 04/28/2011. Care Area Assessment summary and Care plan completion was signed 04/28/2011. On 04/28/2011 at 3:10 PM., Nurse #1 stated she did not have any idea how many MDS's were behind. She knew there were some that needed to be done for the month of March-maybe twenty-five (25)-thirty(30) or more. She stated she had been out on medical leave from November 2010 until February 2010. The MDS coordinator was out on leave in February, returned in March 2011 and went out on leave at the end of March 2011. Nurse #1 stated she could not complete the MDS because she was a licensed practical nurse (LPN). On 04/28/2011at 3:55 PM., Nurse #2 (MDS RN) stated she worked part time and averaged one to two twelve hours day per week working with the MDS's. Nurse #2 stated she had not been to any classes or obtained training with MDS 3.0. She stated she had discussed with administration how far behind they were with MDS's and that they needed help. Nurse #2 stated she had transmitted 52 records today. She did not know how many MDS's were delinquent. 3. Resident # 10 ' s initial admission to the facility was on 11/11/08, but was readmitted on 3/21/11.	F 287		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345249	A. BUILDING _____ B. WING _____	04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 287	Continued From page 25 A review of Resident #10's Minimum Data Set (MDS) revealed the resident was discharged on 3/5/11, reentered the facility on 3/9/11, and there was a significant change completed on 3/13/11. According to the Resident Assessment Instrument (RAI) version 3.0, the MDS's on 3/5/11 and 3/13/11 were not transmitted (sent to Centers of Medicaid and Medicare Services, also known as CMS). On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the other nurse was out on leave. Nurse #1 stated she had informed her supervisor about being short staff for MDS's. The nurse stated the facility hired outside assistance, but MDS's were still behind. Nurse #1 revealed staff was trying to submit MDS's that were still open. On 4/28/11 at 5:15 pm, Nurse #2 revealed she was responsible for completing the MDS ' s. Nurse #2 revealed she was aware of the MDS's not being caught up. The nurse stated the MDS nurse was out on leave. The nurse revealed she was not trained on MDS 3.0 version. The nurse revealed she relied on the MDS nurse out on leave for assistance. Nurse #2 revealed the MDS nurse had been gone since the end of last year. The nurse stated the MDS nurse was coming back, but was not sure when. The nurse revealed the MDS nurse was the person trained to complete MDS 3.0 version. The nurse was unaware of how far behind the staff was on MDS's. The nurse revealed the MDS's in the computer that had the word "transmitted," was recently sent to CMS. The nurse stated staff would receive a confirmation from within 24 hours of being transmitted with an acceptance or denial.	F 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 287	Continued From page 26 4. Resident # 11 was admitted to the facility on 11/17/06. A review of Resident #11's revealed the most recent quarterly Minimum Data Set (MDS) was dated 1/23/11. The facility transmitted the quarterly MDS to Centers of Medicaid and Medicare Services (CMS) on 2/22/11, according to the Resident Assessment Instrument (RAI) version 3.0. The quarterly MDS was transmitted more than 14 days after MDS, was completed. On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the other nurse was out on leave. Nurse #1 stated she had informed her supervisor about being short staff for MDS's. The nurse stated the facility hired outside assistance, but MDS's were still behind. Nurse #1 revealed staff was trying to submit MDS's that were still open. On 4/28/11 at 5:15 pm, Nurse #2 revealed she was responsible for completing the MDS ' s. Nurse #2 revealed she was aware of the MDS's not being caught up. The nurse stated the MDS nurse was out on leave. The nurse revealed she was not trained on MDS 3.0 version. The nurse revealed she relied on the MDS nurse out on leave for assistance. Nurse #2 revealed the MDS nurse had been gone since the end of last year. The nurse stated the MDS nurse was coming back, but was not sure when. The nurse revealed the MDS nurse was the person trained to complete MDS 3.0 version. The nurse was unaware of how far behind the staff was on MDS's. The nurse revealed the MDS's in the computer that had the word "transmitted," was	F 287		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 287	Continued From page 27 recently sent to CMS. The nurse stated staff would receive a confirmation from within 24 hours of being transmitted with an acceptance or denial.	F 287		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide psychological services to manage a resident's depression for 1 of 24 sampled residents (Resident #5). Resident #5 was admitted to the facility on 2/17/09 with cumulative diagnoses that included Depressive Disorder, Diabetes Mellitus, Renal Disease, Generalized Pain, and Osteoarthritis. During the initial tour of the facility on 4/25/11 at 7:35 PM, Resident #5 stated that a staff member had asked the resident if the resident "felt that you would be better off dead" and the response had been "yes" to the staff member. The resident then indicated that the conversation should not continue at that time. There were tears on Resident #5's cheeks as this was discussed. The facility policy titled "Mental/Psychological Adjustment" with a review date of 2-07 revealed	F 319	1.Facility social workers interviewed resident and answers given did not indicate depression. However, because this has been an issue for this resident, the resident and her responsible party have agreed to a psychiatric evaluation. Appointment is being set up with Triad Psychiatric in Greensboro,NC. Chaplain comes to visit resident periodically as well. 2.Any resident who displays mental or psychological adjustment difficulties will receive appropriate treatment and services per policy. 3.Facility social worker will monitor for these difficulties via periodic assessments and report appropriate findings to physicians, responsible party and interdisciplinary team for intervention. Chaplain services as well as psychiatric services are available should a resident require intervention. 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administrator, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed.	5/26/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 319	Continued From page 28 that "The social worker will assess the resident and assist in the development of a plan to help the resident adjust to life changes. A psychologist is available to assess the resident and make recommendations to the physician for treatment." A review of the annual Minimum Data Set (MDS) dated 1/14/11 revealed that Resident #5 responded "yes" on the Mood Interview for "Thoughts that you would be better off dead, or of hurting yourself in some way" with a frequency of "7-11 days (half or more of the days)." A review of the resident's clinical record revealed that on 1/31/11 the Social Worker charted the resident " answered yes to statement interview statement 'thoughts you would be better off dead' with symptom frequency of 2 which is 7-11 out of 14 days. Resident is not at risk for self harm as she is totally dependent upon others for mobility and other ADLs (activities of daily living)." No other notes could be found regarding referral or follow up to this statement. A review of the Care Plan for Resident #5 dated 1/28/11 listed "At times feels down and depressed. Provide reminders of chaplain services." under the diagnosis listed as "diversional activity deficit." Nurse Aide (NA) #2 stated during an interview on 4/28/11 at 10:26 AM that Resident #5 appeared to be depressed and had told NA #5 that she wished she wasn't alive. NA #2 stated she had reported this to the nurse for the resident. NA #3 was interviewed on 4/28/11 at 11:04 AM.	F 319		

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

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F 319	Continued From page 29 She stated that Resident #5 appeared to be depressed and had heard the resident say she would rather not be alive. NA #3 stated she attempted to make Resident #5 feel better and let her know she was important to the NA and others. On 4/28/11 at 11:14 AM, Nurse #5 stated that Resident #5 stayed to herself, rarely got out of bed. She stated that it was hard for Resident #5 to cope with all that had happened to her. The Social Worker was interviewed regarding Resident #5 on 4/28/11 at 11:23 AM. She stated that during the last MDS assessment, the resident had indicated she would just as soon be dead. The Social Worker stated she thought a referral had been made for this resident. At 11:47 AM on 4/28/11, the Social Worker stated that there was no evidence that a referral had been made. On 4/28/11 at 4:40 PM, the Director of Nursing (DON) stated that it was her expectation that any resident answered yes to the question of feeling that they would have been better off dead or had thoughts of self harm an appropriate professional referral would have been made.	F 319		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325	1.Resident # 12's weight was obtained. Weekly weights are being done for eight weeks and are being monitored closely by interdisciplinary team. This resident has been evaluated by dietary manager and registered dietician. The resident is on an appetite stimulant, special diet and supplements. The care plan has been updated as well.	5/26/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 30 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor weights for one (1) of twenty-four (24) residents (Resident #12). Resident #12 had significant weight loss in a one month period. Findings included: 1. Resident #12 was admitted to the facility on 03/19/2011. Cumulative diagnoses included: left hip fracture, Dementia, Diabetes, Gastroesophageal reflux disease (GERD) and iron deficiency. Medical record was reviewed. A fourteen day comprehensive assessment using the Minimum Data Set (MDS) was not in the medical record. Care plan (no date for problem onset) stated Resident #12 was at risk for weight loss related to leaving twenty five (25) per cent or more of food uneaten at most meals. Goals included maintenance of current weight. Approaches included: Regular diet with pureed texture, Dietary manager/ Dietician to evaluate current resident nutritional status, weigh and record as ordered or as deemed appropriate and monitor weights and promptly report significant weight loss or developing trend of continued weight loss. Physician admission orders for 03/19/2011 were	F 325	2.All residents were weighed and weights were reviewed by Dietary Manager and Director of Nurses. All residents with significant weight loss Are being monitored. Their physician, their family/responsible party, registered dietician, and interdisciplinary team were all notified and interventions put into place. 3.The policy and procedure for obtaining weights was revised. Restorative certified nursing assistants are now responsible for obtaining all weights and these weights are reviewed weekly by Dietary Manger and director of Nurses. 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee.The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 31 reviewed. Orders were noted for weekly weights for four weeks on admits and readmits. Medication Administration Records (MAR) were reviewed for March 2011 and April 2011. On 03/19/2011, Resident #12 had a weight recorded at 132 pounds. No further weights were recorded until 04/11/2011 when weight was recorded at 115 pounds. Medical record was reviewed and revealed an admission weight recorded on 03/19/2011 at 133.2 pounds. Weight chart summary sheet stated weight on 04/11/2011 was 115.00 pounds. Braden Risk Assessments for nutrition dated 03/19/2011, 03/25/2011, 04/04/2011, 04/08/2011 and 04/15/2011 documented nutrition as " Probably inadequate. Rarely eats a complete meal and generally eats only about one half (1/2) of any food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement or receives less than optimal amount of liquid diet or tube feeding." Dietary assessment dated 03/23/2011 stated Resident #12 had an admission weight of 132 pounds. Meal percentage intake was twenty-six to seventy-five per cent. Supplements were added twice daily. On 04/26/2011 at 4:00 PM., the Dietary manager stated if weight loss occurred, nursing personnel would send a note to her as well as the Dietician. When weights are obtained and there is a five pound loss, nursing staff would automatically reweigh the resident. The Dietary manager	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 32 stated she checked the hospital weight for Resident #12 and weight was 124 pounds on 03/14/2011. She stated she had not received anything from nursing staff about Resident #12's weight loss and did not have a record of the Dietician being notified of Resident #12's weight loss. On 04/26/2011 at 4:30 PM., Nurse #7 stated she had documented the weight on 04/11/2011 but did not check the previous weight. Nurse #7 stated, normally, she would check the previous weight or the last month's weight. If there was a drastic weight change of four or five pounds either way, the resident would be reweighed. She stated she did not know if the facility had a policy/ protocol regarding weight changes and what to do if there was a big weight change. On 4/26/2011 at 4:55 PM., the Dietician stated she would be consulted for any dietary issues and she had not received anything in her folder for Resident #12. On 04/27/2011 at 8:55 AM., Nurse # 8 stated weights are obtained weekly for four weeks on all new admissions and readmissions. If there is a weight loss or decreased appetite, the physician is faxed and the family is notified. She stated she thought this occurred if there was a five pound weight gain or loss. The weights were recorded on the MAR. Nurse #8 checked the MAR for Resident #12 and stated it was printed wrong on the MAR. She would not have obtained the weight on 03/21/2011 because Resident #12 was admitted on 03/19/2011 and the weight should have been obtained on 03/26/2011. She did not indicate why she did not change the MAR or	F 325		

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F 325	Continued From page 33 document why the weight was not obtained on 03/21/2011. On 04/27/2011 at 9:00 AM., Resident #12 was observed eating breakfast. She was fed by nursing staff. Nursing assistant (NA) #1 stated she usually fed Resident #12 breakfast and lunch. She stated food and fluid intake varied. If Resident #12 ate well at one meal, she usually ate very little at the next meal. At the end of the meal, NA #1 stated Resident #12 had 600 ml. (milliters) of fluid and ate seventy- five (75) per cent of her breakfast. On 04/27/2011 at 11:00 AM., the Director of Nursing was asked regarding the facility weight policy. She stated she did not know if there was a weight policy or protocol but she expected weights to be done as ordered by the physician. If weights were obtained on 03/19/2011, she expected staff to obtain another weight within the next seven days. She was informed of Resident #12's weights for March and April and stated, with the weight of 115 pounds on 04/11/2011, she expected a complete review of eating and intake, reweight in case of error, check to see if there was another weight recorded, if the weight change was from edema, a dietary consult and physician and family notification. On 04/27/2011 at 3:20 PM., the Director of Nursing stated any weights that had a five pound loss or gain would require a reweight as noted on the facility monthly weight sheet. She stated there was not a facility protocol to follow for weight loss or gain other than the reweight.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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

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F 329	Continued From page 34 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist interview, and staff interviews, the facility failed to monitor 5 of 5 sampled residents requiring monitoring for abnormal involuntary movements (residents #5, #11, #15, #24, #14), and failed to ensure residents were free from duplicate therapy for 1 of 4 sampled residents receiving sedatives (resident #14). Findings include:	F 329	1.Residents #5, 11, 15, 24, and 14 taking antipsychotics and raglan, had AIMS tests done and they were filed in their medical record for resident # 14 was reviewed by the consulting pharmacist. Information was provided and a request was sent to the physician for justification for duplicate therapies or discontinuation of the drugs. 2.An audit was done of all resident's medication regimens to determine those residents taking antipsychotics and reglan. AIMS tests were done on all the appropriate residents and were filed on their charts. All residents will have monthly medication reviews done with an additional focus duplicate therapies. 3.The admissions nurse will identify residents being admitted or re-admitted that require AIMs test. The test will be done, filed on the resident's charts and the Director of Nurses notified for tracking purposes. All nurses have been in-serviced to monitor all drug regimens for possible duplicate therapies for follow up, in addition to the monthly reviews by the consulting pharmacist. Follow up to be made with physicians as appropriate. 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, DON, Medicaid Directors, Pharmacist, members of the management team and others as needed.	5/26/11

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

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F 329	Continued From page 35 1. The Facility's Pharmacy Policy, undated, read in part: "In addition, the following labs and monitoring criteria will be ordered for residents in the MNC (Morehead Nursing Center) when the resident is receiving the specified drug in the specified therapeutic class. Antipsychotics - DISCUS or AIMS q (every) 6 months...Reglan - DISCUS or AIMS q 6 months." DISCUS (Dyskinesia Identification System Condensed User Scale) and AIMS (Abnormal Involuntary Movement Scale) tests are clinician-rated scales used to monitor the presence and/or severity of abnormal involuntary movements associated with the use of medications. Resident #5 was admitted to the facility on 1/7/09 with multiple diagnoses including dysphagia, abnormal involuntary movements, and Parkinson's disease. Record review of the resident's clinical record revealed physician orders dated 4/26/09 for Reglan (metoclopramide) 5mg (milligram) qid (four times daily). Metoclopramide is a gastrointestinal agent used for delayed gastric emptying and gastro-esophageal reflux disease (GERD). Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for metoclopramide, stated in part: "has been associated with extrapyramidal symptoms. Use caution in the elderly and with Parkinson's disease; may have increased risk of tardive dyskinesia." Adverse Reactions included in part: acute dystonic reactions, akathisia, Parkinsonian-like symptoms, tardive dyskinesia.	F 329		

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

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F 329	Continued From page 36 Review of the resident's clinical record revealed no documentation of AIMS testing. Review of the facility's AIMS log book revealed no documentation of AIMS results within the previous year. In an interview on 4/28/111 at 4:09PM, the DON (director of nursing) stated the consultant pharmacist monitored the medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS tests were done and put in a notebook but she couldn't locate them. She stated her office had been changed and the notebook may have inadvertently been boxed up. Her expectation was for the AIMS tests to be completed per facility policy, filed, and readily available. 2. The Facility's Pharmacy Policy, undated, read in part: "In addition, the following labs and monitoring criteria will be ordered for residents in the MNC (Morehead Nursing Center) when the resident is receiving the specified drug in the specified therapeutic class. Antipsychotics - DISCUS or AIMS q 6 months...Reglan - DISCUS or AIMS q 6 months." DISCUS and AIMS tests are clinician-rated scales used to monitor the presence and/or severity of abnormal involuntary movements associated with the use of medications. Resident #11 was admitted to the facility on 11/7/06 and readmitted 7/31/10 with multiple diagnoses including GERD. Record review of	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345249	A. BUILDING _____ B. WING _____	04/28/2011

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F 329	Continued From page 37 the resident's clinical record revealed physician orders dated 7/31/10 for Reglan (metoclopramide) 5mg ac (before meals) and hs (at bedtime). Metoclopramide is a gastrointestinal agent used for delayed gastric emptying and gastro-esophageal reflux disease. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for metoclopramide, stated in part: "has been associated with extrapyramidal symptoms. Use caution in the elderly; may have increased risk of tardive dyskinesia." Adverse Reactions included in part: acute dystonic reactions, akathisia, Parkinsonian-like symptoms, tardive dyskinesia. Review of the resident's clinical record revealed no documentation of AIMS testing. Review of the facility's AIMS log book revealed no documentation of AIMS results within the previous year. In an interview on 4/28/111 at 4:09PM, the DON stated the consultant pharmacist monitored the medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS tests were done and put in a notebook but she couldn't locate them. She stated her office had been changed and the notebook may have inadvertently been boxed up. Her expectation was for the AIMS tests to be completed per facility policy, filed, and readily available. 3. The Facility's Pharmacy Policy, undated, read	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 38 in part: "In addition, the following labs and monitoring criteria will be ordered for residents in the MNC (Morehead Nursing Center) when the resident is receiving the specified drug in the specified therapeutic class. Antipsychotics - DISCUS or AIMS q 6 months...Reglan - DISCUS or AIMS q 6 months." DISCUS and AIMS tests are clinician-rated scales used to monitor the presence and/or severity of abnormal involuntary movements associated with the use of medications. Resident #15 was admitted to the facility on 5/13/09 with multiple diagnoses including gastro-esophageal reflux. Record review of the resident's clinical record revealed physician orders dated 8/26/10 for Reglan (metoclopramide) 10mg BID (twice daily). Metoclopramide is a gastrointestinal agent used for delayed gastric emptying and GERD. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for metoclopramide, stated in part: "has been associated with extrapyramidal symptoms. Use caution in the elderly; may have increased risk of tardive dyskinesia." Adverse Reactions included in part: acute dystonic reactions, akathisia, Parkinsonian-like symptoms, tardive dyskinesia. Review of the resident's clinical record revealed no documentation of AIMS testing. Review of the facility's AIMS log book revealed no documentation of AIMS results within the previous year.	F 329		

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F 329	Continued From page 39 In an interview on 4/28/111 at 4:09PM, the DON stated the consultant pharmacist monitored the medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS tests were done and put in a notebook but she couldn't locate them. She stated her office had been changed and the notebook may have inadvertently been boxed up. Her expectation was for the AIMS tests to be completed per facility policy, filed, and readily available. 4. The Facility's Pharmacy Policy, undated, read in part: "In addition, the following labs and monitoring criteria will be ordered for residents in the MNC (Morehead Nursing Center) when the resident is receiving the specified drug in the specified therapeutic class. Antipsychotics - DISCUS or AIMS q 6 months...Reglan - DISCUS or AIMS q 6 months." DISCUS and AIMS tests are clinician-rated scales used to monitor the presence and/or severity of abnormal involuntary movements associated with the use of medications. Resident #24 was admitted to the facility on 7/2/09 with multiple diagnoses including bipolar disorder and schizophrenia. Record review of the resident's clinical record revealed physician orders dated 7/11/10 for Seroquel (quetiapine) 50mg hs. Seroquel is an antipsychotic agent used for the treatment of bipolar disorder and schizophrenia. Lexicomp's Drug Information Handbook, 14th	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 40 edition, Warnings/Precautions for Seroquel, stated in part: "tardive dyskinesia." Adverse Reactions included: involuntary movements. Monitoring Parameters included: abnormal involuntary movement scale (AIMS). Review of the resident's clinical record revealed no documentation of AIMS testing. Review of the facility's AIMS log book revealed no documentation of AIMS results within the previous year. In an interview on 4/28/111 at 4:09PM, the DON stated the consultant pharmacist monitored the medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS tests were done and put in a notebook but she couldn't locate them. She stated her office had been changed and the notebook may have inadvertently been boxed up. Her expectation was for the AIMS tests to be completed per facility policy, filed, and readily available. 5a. The Facility's Pharmacy Policy, undated, read in part: "In addition, the following labs and monitoring criteria will be ordered for residents in the MNC (Morehead Nursing Center) when the resident is receiving the specified drug in the specified therapeutic class. Antipsychotics - DISCUS or AIMS q 6 months ...Reglan - DISCUS or AIMS q 6 months." DISCUS and AIMS tests are clinician-rated scales used to monitor the presence and/or	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 41 severity of abnormal involuntary movements associated with the use of medications. Resident #14 was admitted to the facility on 6/30/09 with multiple diagnoses including gastroparesis, diabetes, and esophageal reflux. Record review of the resident's clinical record revealed physician orders dated 3/25/11 which read "restart Reglan 5mg qhs." Reglan (metoclopramide) is a gastrointestinal agent used for delayed gastric emptying, diabetic gastroparesis, and GERD. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for metoclopramide, stated in part: "has been associated with extrapyramidal symptoms. Use caution in the elderly; may have increased risk of tardive dyskinesia." Adverse Reactions included in part: acute dystonic reactions, akathisia, Parkinsonian-like symptoms, tardive dyskinesia. Review of the resident's clinical record revealed no documentation of AIMS testing. Review of the facility's AIMS log book revealed no documentation of AIMS results within the previous year. In an interview on 4/28/111 at 4:09PM, the DON stated the consultant pharmacist monitored the medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS test was done and put in a notebook but she couldn't locate it. She stated her office had been changed and the notebook	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 42 may have inadvertently been boxed up. Her expectation was for the AIMS tests to be completed per facility policy, filed, and readily available. 5b. Resident #14 was admitted to the facility on 6/30/09 with multiple diagnoses including insomnia. Record review of the resident' s clinical record revealed physician orders dated 8/21/10 for Ambien (zolpidem) 5mg qhs (every night at bedtime) for sleep, and orders dated 11/26/10 for Remeron (mirtazepine) 7.5mg qhs for insomnia. Ambien is a sedative indicated for the short-term treatment of insomnia. Remeron is an antidepressant with a non-FDA (Federal Drug Administration) approved indication for sleep. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for Ambien, stated in part: "use caution in the elderly. Effects with other sedative drugs may be potentiated." Record review of the resident's medication administration record (MAR) revealed Ambien and Remeron had been given nightly since 11/26/10. Record review of the physician's progress notes dated 1/28/11, 3/29/11, and 4/20/11 revealed no documentation of the clinical need for two medications for insomnia. Record review of the consultant pharmacist's progress notes dated 12/10/10, 1/18/11, 2/28/11, and 4/14/11 revealed no documentation of the clinical need for two medications for insomnia.	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 43 In an interview on 4/28/11 at 12:04PM, the Consultant Pharmacist stated the resident's Remeron had been changed from as needed to scheduled on 11/26/10, and the Ambien had been continued. She stated there would be no clinical reason for both medications to be given concurrently. In a telephone interview on 4/28/11 at 3:05PM, the resident's nurse on second shift (Nurse #9) stated she was aware that Remeron and Ambien were both indicated for sleep. She stated the Ambien was not working well for the resident and Remeron was added. Nurse #9 stated the Remeron was usually given at 9PM and the Ambien at 11PM. In an interview on 4/28/11 at 4:09PM, the Director of Nursing stated the consultant pharmacist identified duplicate therapy during the monthly drug regimen reviews. The DON stated she would expect the pharmacist to have requested an evaluation from the physician to consider discontinuing one of the sedative medications for resident #14. She stated she would expect to have documentation in the resident's chart if the physcian wanted to continue both medications.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	1.Routine drug regimen reviews were completed on residents #3, 4, 5, 8, 11, 23, 24. A review of duplicate drug therapy was completed on resident #14, physician was provided information and response requested.	5/26/11

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

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F 428	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist interview, and staff interviews, the facility failed to ensure the consultant pharmacist completed drug regimen reviews once a month for 7 of 26 sampled residents (residents #3, #4, #5, #8, #11, #23, #24), and failed to ensure the consultant pharmacist identified duplicate therapy for 1 of 4 sampled residents receiving sedatives (resident #14). Findings include: 1. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly." Resident #3 was admitted to the facility on 7/30/10 with multiple diagnoses including renal insufficiency, hypertension, history of stroke, and atrial fibrillation. Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for October 2010, November 2010, or December 2010. In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She	F 428	2.All residents were screened in May 2011 to ensure a monthly drug regimen had been completed. Medication regimen review will be done monthly on all active residents. 3.The Hospital Pharmacy Director reviewed pertinent regulations and procedures for monthly regimen review and the role of the consulting pharmacist with to the consulting pharmacist. The Director of Nurses will monitor the monthly medication regimen reviews to ensure compliance. 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administrator, Director of Nursing, Medicaid Directors, Pharmacist, members of the management team and others as needed.	

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

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F 428	Continued From page 45 indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the Director of Nursing (DON) stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 2. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly." Resident #4 was admitted to the facility on 4/25/05 and readmitted 2/16/11 with multiple diagnoses including diabetes, chronic obstructive pulmonary disease, hypertension, cerebrovascular accident, and atrial fibrillation. Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for November 2010 or March 2010. In an interview on 4/28/11 at 11:01AM, the	F 428		

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F 428	Continued From page 46 Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 3. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly." Resident #5 was admitted to the facility on 1/7/09 with multiple diagnoses including diabetes, chronic kidney disease, coronary artery disease, and history of myocardial infarction. Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for June 2010, July 2010, September 2010, or January 2011.	F 428		

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MOREHEAD NURSING CENTER	205 EAST KINGS HWY EDEN, NC 27288

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F 428	Continued From page 47 In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 4. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly." Resident #8 was admitted to the facility on 8/27/09 and readmitted on 11/17/11 with multiple diagnoses including diabetes, hypertension, dementia, and depressive disorder. Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug	F 428		

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F 428	Continued From page 48 regimen review for May 2010, September 2010, and January 2011. In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 5. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly." Resident #11 was admitted to the facility on 11/7/06 and readmitted on 7/31/10 with multiple diagnoses including diabetes, hypertension, dementia, coronary artery disease, and history of myocardial infarction.	F 428		

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

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F 428	Continued From page 49 Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for September 2010 and January 2011. In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 6. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly." Resident #23 was admitted to the facility on 6/16/05 and readmitted on 1/7/10 with multiple	F 428		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345249	A. BUILDING _____ B. WING _____	04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOREHEAD NURSING CENTER	205 EAST KINGS HWY EDEN, NC 27288

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F 428	Continued From page 50 diagnoses including hypertension, atrial fibrillation, seizure disorder, coronary artery disease, dementia, and depressive disorder. Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for September 2010 and January 2011. In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 7. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly."	F 428		

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F 428	Continued From page 51 Resident #24 was admitted to the facility on 7/2/09 with multiple diagnoses including diabetes, hypertension, and bipolar disorder. Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for October 2010 and March 2011. In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 8. Resident #14 was admitted to the facility on 6/30/09 with multiple diagnoses including insomnia. Record review of the resident's clinical record revealed physician orders dated 8/21/10 for Ambien (zolpidem) 5mg qhs (every night at	F 428		

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F 428	Continued From page 52 bedtime) for sleep, and orders dated 11/26/10 for Remeron (mirtazepine) 7.5mg qhs for insomnia. Ambien is a sedative indicated for the short-term treatment of insomnia. Remeron is an antidepressant with a non-FDA (Federal Drug Administration) approved indication for sleep. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for Ambien, stated in part: "use caution in the elderly. Effects with other sedative drugs may be potentiated." Record review of the resident's medication administration record (MAR) revealed Ambien and Remeron had been given nightly since 11/26/10. Record review of the physician's progress notes dated 1/28/11, 3/29/11, and 4/20/11 revealed no documentation of the clinical need for two medications for insomnia. Record review of the consultant pharmacist's progress notes dated 12/10/10, 1/18/11, 2/28/11, and 4/14/11 revealed no documentation of the clinical need for two medications for insomnia. In an interview on 4/28/11 at 12:04PM, the Consultant Pharmacist stated the resident's Remeron had been changed from as needed to scheduled on 11/26/10. She acknowledged the Ambien had also been continued. She stated there would be no clinical reason for both medications to be given concurrently. She stated she should have evaluated the Ambien for discontinuance. In an interview on 4/28/11 at 4:09PM, the DON	F 428		

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F 428	Continued From page 53 stated the consultant pharmacist identified duplicate therapy during the monthly drug regimen reviews. The DON stated she would expect the pharmacist to have requested an evaluation from the physician to consider discontinuing one of the sedative medications for resident #14. She stated she would expect to have documentation in the resident's chart if the physcian wanted to continue both medications.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

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F 441	Continued From page 54 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to disinfect a glucometer for 1 of 1 sampled resident (resident #26) observed receiving blood glucose monitoring. Findings include: The facility's policy titled Blood Glucose Testing and Cleaning of Meter, revised 3/08, read in part: "Cleaning the Exterior of the Meter - The exterior of the meter must be cleaned between each resident by wiping down with Sani-cloth wipes." The Center for Disease Control (CDC) and Prevention Guidelines for Glucose Monitoring read in part: "Any time blood glucose monitoring equipment is shared between individuals there is a risk of transmitting viral hepatitis and other blood borne pathogens." The CDC "Recommended Infection Control and Safe Injection Practices to Prevent Patient-to-Patient Transmission of Bloodborne Pathogens" read in part: "Environmental surfaces such as glucometers should be decontaminated regularly and anytime	F 441	1.Upon notification of improper technique, the nurse was instructed in proper sanitation procedure and the glucometer was sanitized prior to further resident use. 2.All nurses were reminded of the proper technique. This will also be reviewed during a skills fair 5/24/11 and 5/31/11. Attendance is mandatory nursing staff. 3.In-services were conducted 5/19/11 and 5/20/11 to review proper technique with all professional nursing staff. Mandatory skills fairs are done annually in May to update Nurse Competencies. 4. The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administrator, Director of Nurses, Medical Directors, Pharmacist, members of the management team and others as needed.	5/26/11

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F 441	Continued From page 55 contamination with blood or body fluids occurs or is suspected. Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected." Accu-check or fingerstick blood sugar (FSBS) tests involve sticking a resident's finger for a blood sample, which is then placed on a strip. The strip goes into a glucose meter that reads the blood sugar level. Resident #26 was admitted to the facility on 3/25/11 with multiple diagnoses including diabetes. Record review of the resident's clinical record revealed a physician order dated 3/25/11 for FSBS BID (twice daily). Observation on 4/27/11 at 5:53PM revealed nurse #10 preparing to obtain a finger stick blood sugar for resident #26. Nurse #10 removed the glucometer from its carrying case and inserted a test strip into the glucometer. Nurse #10 wiped the resident's finger with an alcohol pad, obtained a blood sample by disposable lancet, and applied a drop of blood to the test strip. After reading the test results, Nurse #10 removed the test strip. Nurse #10 disposed of the used test strip, alcohol pad, and lancet. Nurse #10 then cleaned the glucometer with a 70% alcohol disposable wipe and placed the glucometer back into its carrying case. Nurse #10 did not disinfect the glucometer after use. In an interview on 4/27/11 at 6:05PM, Nurse #10 stated she had been working at the facility for one month and was trained how to clean the	F 441		

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F 441	Continued From page 56 glucometer by the floor nurse. Nurse #10 acknowledged she had used alcohol only to clean the glucometer after using it for resident #26. Nurse #10 stated she normally used the sani-wipes, which contained a disinfectant, to clean and disinfect the glucometer. Nurse #10 indicated there were no sani-wipes on her cart at the time. She stated "I should have gotten the sani-wipes, I just forgot, I was nervous." In an interview on 4/28/11 at 4:09PM, the Director of Nursing (DON) stated Nurse #10 had been trained in general orientation and also by the facility's educator and the floor nurse assigned to train her. The DON stated Nurse #10 had been trained specifically on the proper procedure for glucometer use, cleaning, and storage. She indicated Nurse #10 said she was nervous during the FSBS observation. The DON stated she expected the staff to clean and disinfect glucometers according to facility policy.	F 441		

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	345249	A. BUILDING 01 - MAIN BUILDING 0101 B. WING	05/26/2011

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/26/2011 the shop contained gas fired water heaters which makes the room now a severe hazardous area which must be both one hour construction and sprinkled. There were penetrations in the ceiling of the shop that were not properly sealed to maintain the one hour rating of the room. 42 CFR 483.70 (a)	K 029	1. The penetrations in the ceiling of the shop were repaired on 5/27/11.	5/27/2011
			2. Maintenance personnel will inspect the facility to locate and repair any penetrations in ceilings.	7-6-2011
			3. Maintenance will inspect one quarter of the facility every 3 months to ensure penetrations are identified and repaired. A preventative maintenance (PM) standing work order will be developed.	6/30/2011
			4. The results of audit tools, edits, monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed	6/30/2011
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: A. Based on observation on 05/26/2011 the facility could not show that the lights in the court yard were on the emergency generator. 42 CFR 483.70 (a)	K 046	1. Court yard lights will be added to the emergency generator circuit.	7/6/2011
			2. Maintenance personnel will review facility lighting to ensure all areas needing emergency generator circuit will be assessed.	7/6/2011
			3. The lighting in court yard will be upgraded to generator power.	7/6/2011
K 047	NFPA 101 LIFE SAFETY CODE STANDARD	K 047		

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

Mary T Whitehurst — Administrator — 6-17-2011

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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K 047 SS=D	Continued From page 1 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/26/2011 there were no Exits directing as how to egress from the court yard. 42 CFR 483.70 (a)	K 047	K 046 4.The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed	7/6/2011
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on05/26/2011 the electrical closet on the East hall was not covered by the sprinkler system. 42 CFR 483.70 (a)	K 056	K 047 1.Illuminated exit signs will be mounted in the courtyard. 2.Maintenance personnel will assess the court yard for adequacy of exit signs accordance with regulation. 3.Signs showing exits will be mounted above appropriate doors and connected to the emergency power generator. Upon completion, staff and residents will be given an in-service on the exit signs and procedures. 4.The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed	7/6/2011 7/6/2011 7/6/2011 7/6/2011

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K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/26/2011 the accelerator valves on the two dry sprinkler systems were not supervised. 42 CFR 483.70 (a)	K 061	K 056 1.The sprinkler contractor will install a sprinkler head in the East hall electrical closet. 2.Maintenance personnel will inspect facility to ensure adequate sprinkler coverage. 3.During quarterly sprinkler inspections and tests, the contractor will be required to review sprinkler locations and coverage to ensure compliance with regulations. 4.The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed K 061 1.Sprinkler contractor will install a monitor alarm on the compressed air valve input line to the accelerator of the main sprinkler riser. 2.Sprinkler contractor will inspect and test the system to ensure all valves are monitored as required by regulation. 3.The sprinkler contractor during quarterly visits will inspect and test monitored valves and alarm systems. 4.The results of audit tools, edits , monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed	7/6/2011 6/30/2011 7/6/2011 7/6/2011 7/6/2011 7/6/2011 7/6/2011 7/6/2011