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
	345307	A. BUILDING ______ B. WING ______	C 07/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

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F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to position mattresses and side rails in such a manner to maintain the safety for two (2) of ten (10) sampled residents who utilized side rails. (Resident #2 and Resident #8) Immediate jeopardy began on 03/07/11 when staff found Resident #2 with her head under the side rail and the rail resting on her neck. This accident occurred when the head of the bed was raised and the resident slid to the gap created between the mattress and side rail. Immediate jeopardy was removed on 07/08/11 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee education. The findings are:	F 323	Disclaimer Statement: Preparation and submission of this plan of correction is in response to the 2567 from the survey of July 5, 2011 to July 8, 2011 and does not constitute an agreement of admission by Meadow Wood Nursing Center of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies, the findings, conclusions, and actions of the agency. This plan of correction (and any attached documents) is prepared and submitted solely because of state and federal regulation and also functions as the facility's credible allegations of compliance Finding F323 On 3/07/2011 concerning resident # 2, the facility nursing staff raised the side rail, and pushed left side of the bed against the wall. The staff communicated the incident in the Maintenance Book and faxed the physician.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Long
TITLE: Admenidrator
(X6) DATE: 8/3/11

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.

Original Signature Date: 7-29-11

RECEIVED
AUG 3 2011
BY: DRR

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F 323	Continued From page 1 1. A review of the bed rail operating instructions from the bed and side rail manufacturer for lowering and raising the bed rail revealed "caution: there will be a gap between the bed rails and the mattress when the bed is in the semi Fowler position (head of bed elevated approximately 30 degrees). Put the bed rails in the "MID" position to eliminate the gap." These operating instructions applied to all beds in the facility with full side rails. Resident #2 was admitted on 01/11/05 with diagnoses including stroke, left sided paralysis, aphasia, abnormal posture, and dementia. A review of the annual Minimum Data Set (MDS) dated 12/20/10 revealed the resident had short term and long term memory problems and severe impairment in cognition. The MDS also indicated Resident #2 required extensive assistance to move to and from a lying position in bed, turn from side to side, and position her body in bed. A review of a Siderail Utilization Assessment dated 12/21/10 for Resident #2 stated side rails were indicated and served as an enabler to promote independence in position and bed mobility. In addition it stated Resident #2 was non-ambulatory, had alteration in safety awareness due to a cognitive decline, had a history of falls, demonstrated poor bed mobility of difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control and was on medications which required increased safety precautions. A review of the Care Area Assessment dated 12/21/10 indicated side rails x (times) two (2) used to aid in turning and positioning while in bed.	F 323	On 3/08/2011 The Maintenance Director at the facility removed the side rails and placed a protective bedside mat for Resident #2 as directed by the Administrator. On 3/16/2011 a personal alarm while in chair was placed on resident #2. To ensure that this alleged deficient practice does not currently exist, the facility has completed a side rail assessment on Resident #2 on 7/08/2011.The Kardex (information tool used by the nursing assistant to carry out approaches noted on the residents plan of care) and care plan of Resident #2 were re-evaluated on 7/08/2011 by the MDS Coordinator and found all previous approaches (discontinuing side rails, using a low bed with bed side mat and bed alarm) are appropriate.	

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F 323	Continued From page 2 The Plan of Care related to behaviors dated 12/23/10 indicated Resident #2 was "resistive with care (combative) and exhibited restless behavior (banged on tables/doors with fist and fidgeted)." A review of an incident report dated 03/07/11 at 11:10 p.m. revealed Resident #2 "got her head under bed rail and rail was pressing down on resident's neck. A note was left in the maintenance request book to look at bed rail. Bed rails removed from bed and mat by bedside." The incident report was signed by Licensed Nurse (LN) #1. A review of the nurse's notes on 03/08/11 stated "at approximately 11:10 p.m. last night this nurse was informed that resident had somehow gotten head under left bedrail and it was resting on resident's neck on right side of neck with substantial pressure. No apparent injury found upon physical assessment. Responsible party notified via phone call. Also Nurse Practitioner notified via physicians fax and communication book" The nurse's note was also signed by LN #1. A review of the updated care plan dated 03/08/11 and nurse's notes dated 03/09/11 for Resident #2 stated the bed rails were removed as of 03/08/11. These documents were signed by the MDS Coordinator. A review of the Abnormal Involuntary Movement Scale (AIMS) dated 03/24/11 revealed Resident #2 had mild upper extremity movements and no lower extremity movements.	F 323	On 7/06/2011 the splayed right side rail was repaired. On 7/7/2011 the MDS Coordinator conducted a side rail assessment on Resident #8 using the side rail evaluation form. The form evaluates the need for side rails based on the following factors that include but are not limited to the resident's medical condition, bed safety, fall history, mobility, expressed desire and risk factors. Utilizing this assessment form, it was determined Resident #8 could safely use ½ rails for turning and positioning. The Kardex and care plan was also updated to reflect this change. The Maintenance Director at the facility removed the full length side rails and they were replaced with ½ length side rails for Resident #8 and lowered the bed as directed by MDS Coordinator. Beginning 7/08/2011 Resident #8 is audited daily twice per shift, using a facility audit tool which consists of proper positioning of side rails, side rail locked in place, space between mattress and rail is less than four inches, side rail is securely fastened , and the locking mechanism is functioning. This audit will occur for 60 days then weekly for an additional 4weeks. Following the four week audit the frequency will become monthly if compliance has been achieved..	

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F 323	Continued From page 3 An interview on 07/06/11 at 3:28 p.m. with the Minimum Data Set (MDS) Coordinator revealed she revised Resident #2's care plan on 03/08/11 by deleting the side rails as an intervention. An interview on 07/06/11 at 3:37 p.m. with the Maintenance Director revealed Resident #2 had full side rails on her bed prior to the incident on 03/07/11. He explained when he came to work on the morning of 03/08/11 the former Administrator and Director of Nursing told him to remove the side rails from Resident #2's bed. He stated he removed the rails and did not recall they were damaged or out of position. He explained he was also told to push one side of her bed up against the wall and put a mat on the floor by the opposite side of the bed. He confirmed that Resident #2 was still in the same bed as the one she had on 03/07/11 but the bed was in a low position with the side rails removed. An interview on 07/06/11 at 5:18 p.m. with LN #1 revealed on 03/07/11 he was at the nursing station when NA #9 told him the bed rail was down on Resident #2's neck. He stated he immediately went to Resident #2's room and observed the resident lying on her side with her neck under the bed rail. He explained he had to release the side rail and remove it off the resident's neck. LN #1 stated the resident was not in any respiratory distress. He stated he pulled the resident back over in bed and assessed her. He explained he looked at her neck, did not see any bruising and would have charted it in his nurse's note if he had seen anything unusual. He stated he documented "substantial pressure" in his nurse's note to mean	F 323	Resident #2 is audited using the facility audit tool to ensure that her mats are properly placed on the floor at the bedside. Each bed is assessed using the side rail audit tool at the beginning of each shift by the assigned nursing assistant. If the audit tool reflects interventions for Resident #2 and Resident #8 is needed, corrective action will be taken immediately to provide the appropriate intervention. The findings of these audits are reported immediately to the charge nurse, who in turn will call the DON. These immediate corrective actions can include but are not limited to repositioning of resident, placing a barrier such as pads or rolled up blankets to close any potentially dangerous gap(s), adjusting the side rail to a safe level and any mechanical failures reported to the Maintenance Director. The charge nurse will inform the Administrator and/or DON. The Administrator and/or DON also reviews the side rails audits daily and will continue for the next 60 days. Thereafter	

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F 323	Continued From page 4 the actual weight of the side rail itself. He verified Resident #2 had full length rails on both sides of her bed and the head of her bed was raised up approximately 20 to 30 degrees. LN #1 stated he did not call the physician because he did not see any injury and faxed a note to the doctor after the incident happened. He explained he did not remember anyone in administration talking with him about the incident after it occurred. He further explained the next time he came to work he noticed the rails had been removed from the resident's bed. Her bed was pushed up against the wall and a mat was on the floor on the opposite side of the bed. LN #1 stated he didn't recall Resident #2 ever attempting to get out of bed. When asked, LN #1 stated he was unaware who had cared for Resident #2 on the previous shift or how long the resident had been positioned with her head and neck under the side rail. During a telephone interview on 07/07/11 at 1:25 p.m. NA #9 revealed she was assigned to care for Resident #2 on 03/07/11 during the 11:00 p.m. to 7:00 a.m. shift. She explained she was walking up the hall on her first round and discovered the resident lying on her side facing out of the bed with the bottom of the full side rail resting on her neck. She further stated the resident's color was pink and she did not note any respiratory distress when she entered the room. An interview with the current Director of Nursing on 07/08/11 at 11:34 a.m. revealed she reviewed the Nurse Aide flow sheets for 3:00 p.m. to 11:00 p.m. on 03/07/11 and determined NA #6 was listed on the schedule to care for Resident #2. She further stated she was not working in the facility at that time and was unable to confirm who	F 323	this will be checked Weekly for 4 weeks by the DON or charge nurse using a tool to check for proper positioning of resident in bed with side rails , and use of proper equipment . Thereafter this will be checked monthly ongoing by the DON. The maintenance Director or charge nurse will inspect the side rail equipment daily for 60 days to ensure that it fits properly and in good working order Thereafter he will check monthly using a safety audit tool. Non-compliant issues will be addressed immediately by the Administrator and or DON and interventions put in place. In addition, all non-compliant findings and interventions will be addressed at monthly QA meetings. To ensure that others are not affected by the same alleged deficient practice The MDS Coordinator completed a side rail assessment form on two residents who were using full side rails. The form evaluates the need for side rails based on the following factors that include but are not limited to the resident's medical condition, bed safety, fall history, mobility, expressed desire and risk factors. Utilizing this assessment form, it was determined that the residents could safely use ½ rails	

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F 323	Continued From page 5	F 323		

actually cared for the resident on 03/07/11.

A telephone interview with NA # 6 on 07/08/11 at 12:11 p.m. revealed she worked from 3:00 p.m. to 11:00 p.m. on 03/07/11 but she did not care for Resident #2. She further stated she did not know who took care of Resident #2 during the evening of 03/07/11 and she did not go into Resident #2's room.

Review of the audit document entitled "side rails" dated 04/01/11 was performed by LN #2. A review of the audit results revealed six beds were marked with a star as "large space with head of bed up." There was no documentation available indicating what if any changes or corrective actions were made by administrative staff.

Interview on 07/07/11 at 9:50 a.m. with LN #2 revealed following the accident on 03/07/11 involving Resident #2, administration asked her to check all resident beds (spaces between the mattresses and side rails with the head of the beds rolled up). She stated she found four to six beds with what she considered "too large" a space between the rails and bed. She stated she gave the information to administrative staff, who no longer worked in the facility and was unaware of any follow-up or corrective actions that were performed based on the findings of the 04/01/11 audit.

2. Resident #8 was admitted to the facility with diagnoses including obesity, altered mental state, and lumbar spine degeneration. The latest Minimum Data Set (MDS) dated 04/18/11 indicated impaired cognition and extensive staff assistance for all care including bathing,

Provider's Plan of Correction (F 323):

for turning and positioning. The Kardex and care plan was also updated to reflect this change. The Maintenance Director at the facility removed the full length side rails and they were replaced with ½ length side rails for both residents. After appropriate assessment The Maintenance Director was directed to and has removed all full side rails as of 07/26/2011. To ensure that other residents are not affected by non-compliant side rail issues, all residents with side rails had a side rail assessment completed by the facility's MDS Coordinator on 7/08/2011. All resident care plans and Kardex were updated as of 7/08/2011. All nurses, certified nursing assistants, housekeepers, and department managers were in-serviced by the Facility Administrator, Facility Administrative Manager or DON on 7/07/2011 and 7/08/2011. Any individual who has not completed this in service by 7/08/2011 will not be allowed to work until completion is achieved.

The in service included: proper positioning of full side rails when head of bed is elevated, side rails locked in place, checking for space of less than four inches

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F 323	Continued From page 6 grooming, dressing, toileting, and transfers. The MDS assessment review revealed impaired mobility of both lower extremities and no impairment of upper extremities. A review of Resident #8's care plan updated 04/28/11 revealed Resident #8 was at risk for skin breakdown due to immobility, diagnosis of diabetes, and incontinence. Approaches included change position routinely and side rails x (times) two (2) to aid in turning and positioning. Review of the Siderail Utilization Assessment forms dated 04/19/11 for Resident #8 revealed the resident was non-ambulatory, the resident had alteration in safety awareness due to cognitive decline, demonstrated poor bed mobility of difficulty moving to a sitting position on the side of the bed, the resident had difficulty with balance or poor trunk control, was on medication which would require increased safety precautions, and was currently using side rails to enable positioning or support. The resident expressed desire to have side rails raised while in bed. An observation on 07/05/11 at 11:58 a.m. revealed Resident #8 lying in her bed on her back with her head and shoulders positioned in the middle of the mattress. Full side rails were observed in the up position on each side of the bed. The entire left side rail and foot end of the right side rail were observed fitting flush with the bed frame. The right side rail was splayed outward at the head of the bed with the mattress shifted against that portion of the side rail. This position exposed the bed frame on the left side leaving a gap between the mattress and the head portion of the left side rail of approximately eight	F 323	between mattress and bed, side rail is securely fastened to the bed, and when raising and lowering the side rail the bed functions with no risk of entrapment. Each certified nursing assistant was instructed to complete a side rail audit tool by auditing the residents that they are assigned before the start of duty beginning second shift 7/08/2011. Each staff member was in serviced on 7/08/2011. Those not in attendance were not allowed to work until attendance was achieved. The in service consisted of an explanation of the citation, education on appropriate usage of side rails to prevent the risk of entrapment. The licensed staff was instructed on proper usage and reporting of the audit tool. This in service was conducted by the Administrator on 7/08/2011. After the 3rd shift on 7/08/2011 the auditing will take place at the beginning and end of each shift. Any findings during the audit process that require corrective actions by the nursing assistant will be taken immediately to ensure resident safety, and these audit findings will be reported to the charge nurse. These	

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F 323	Continued From page 7 (8) inches. An observation on 07/05/11 at 3:15 p.m. revealed the positions of both side rails and mattress unchanged. Resident #8 remained with her head and shoulders in the middle of the mattress. An observation on 07/05/11 at 5:27 p.m. revealed Resident #8 in bed with head of bed in the up position eating her supper without assistance. The right and left side rails remained in the up position. The bed frame continued to be exposed at the head of the bed on the left side in the manner as described above. At 6:00 p.m. on 07/05/11 an observation of Resident #8's mattress and right side rail position was made with the Maintenance Director, Administrator, and Administrative Manager. The position of the side rails and mattress and the gap created at the head of the bed on the left side remained unchanged. The Maintenance Director explained the right side rail latch had become disengaged from the bed frame at the head of the bed causing the rail to stretch outward from the bed. The Administrator was observed unable to lower the right rail. The Maintenance Director stated he previously observed side rails in this facility to splay in this manner before, although, it was not a frequent occurrence. He was unable to explain why it happened. He continued he had no prior knowledge of the separation observed on Resident #8's bed. The Maintenance Director, Administrator, and Administrative Manager verified the resident could possibly place her head in the gap created on the left side of the bed and should be fixed immediately. They also acknowledged this situation should have been	F 323	Immediate corrective actions include but are not limited to repositioning of resident, placing a barrier such as pads or rolled up blankets to close any potentially dangerous gap, adjusting the side rail to a safe level and any mechanical failures reported. The Administrator is to be alerted immediately of any issues that cannot be immediately resolved. The charge nurse informs the Administrator and/or DON of any issue reported. The Administrator and/or DON also reviews the side rail audit daily and will continue so for the next 30 days. They will then review them weekly for the next 4 weeks. Non-compliant issues will be addressed immediately by the Administrator and or DON and interventions put in place. In addition, all non-compliant findings and interventions as well as outcomes will be addressed at monthly QA meetings. Each bed in the facility was assessed on 7/08/2011 by the Director of Maintenance to ensure that the side rails are in working condition, installed properly and do not impose an entrapment risk. The audit and assessment revealed 28 full side rails in	

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F 323	Continued From page 8 reported by nursing and direct care staffs. An interview on 07/05/11 at 6:10 p.m. with Licensed Nurse #2 revealed she had administered medications to Resident #8 throughout the day. She stated she did not observe the right side rail stretched out from the bed with the bed frame exposed at the left side of the head of the bed. An interview on 07/06/11 at 9:12 a.m. with Nursing Assistant (NA) #3 revealed she provided Resident #8 with care during the 7:00 a.m. to 3:00 p.m. shift on 07/05/11. She stated she did not notice the splayed position of the right side rail nor the exposed bed frame on the left side of the head of the bed. NA #3 added she did not attempt to lower the right side rail anytime on 07/05/11. The Administrator was informed of Immediate Jeopardy on July 7, 2011 at 4:35 p.m. for Resident #2 and Resident #8. The facility presented a credible allegation of compliance which included: For Resident #2: On 3/07/2011 the facility nursing staff raised the side rail, and pushed left side of the bed against the wall. The staff communicated the incident in the Maintenance book and faxed the physician. On 3/08/2011 The Maintenance Director at the facility removed the side rails and placed a protective bedside mat for Resident #2 as directed by the Administrator. On 3/16/2011 a personal alam was placed on Resident #2 while in chair. To ensure that this alleged deficient	F 323	use. Out of that 28, 8 side rails were removed and 14 changed to half rails. On 7/08/2011 using the mentioned side rail audit tool, each resident was checked by the DON or Administrator to ensure his/her side rail does not impose any entrapment risk. No gaps larger than 4 inches between the mattress and side rails were found, all side rails were fastened correctly and tightly and no evidence of potential entrapment was found. The Maintenance Director or Nursing Supervisor will check each side rail daily for the next 60 days to ensure that side rails are securely fastened and no space greater than 4 inches exist. Thereafter he/she will complete a tool weekly for four weeks, then monthly after Any non-compliant findings will be addressed immediately with corrective actions to ensure resident safety. Any findings and interventions will be reported by the DON to QA for evaluation. To ensure that the system of preventing accidents of potential bed rail entrapment remains in place and that the facility remains in compliance; the DON or Administrator will audit daily the completed side rail audit tools completed by the nursing assistant for the first 30 days then weekly for the following four weeks, and monthly thereafter. The Maintenance Director will complete an	

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F 323	Continued From page 9 practice does not currently exist, the facility has completed a side rail assessment on Resident #2 on 7/08/2011. The Kardex (information tool used by the nursing assistant to carry out approaches noted on the residents plan of care) and care plan of Resident #2 were reevaluated on 7/08/2011 by the MDS Coordinator and found all previous approaches (discontinuing side rails, using a low bed with bed side mat and bed alarm) are appropriate. Resident #8: On 7/06/20111 the splayed right hand rail was repaired. On 7/7/2011 the MDS Coordinator conducted a side rail assessment on Resident #8 using the side rail evaluation form. The form evaluates the need for side rails based on the following factors that include but are not limited to the resident's medical condition, bed safety, fall history, mobility, expressed desire and risk factors. Utilizing this assessment form, it was determined Resident #8 could safely use ½ rails for turning and positioning. The Kardex and care plan was also updated to reflect this change. The Maintenance Director at the facility then removed the full length side rails, replaced with ½ length side rails for Resident #8 and lowered the bed as directed by MDS Coordinator. Beginning 7/08/2011 Resident #8 will be monitored using a facility audit tool which consists of proper positioning of side rails, side rail locked in place, space between mattress and rail is less than four inches, side rail is securely fastened in position, and the locking mechanism is functioning. Resident #2 is assessed to ensure that her mats are properly placed at bedside. Each bed is assessed using the side rail audit tool at the beginning of every shift by the assigned nursing assistant. If the audit tool	F 323	audit consisting of making sure all rails fit the bed properly and are in good working order weekly for 60 days, then monthly as this will be added to the monthly maintenance audit tool. The Administrator will complete a report weekly of all identified issues that were non-compliant, and the corrective action taken. A copy of this report will be submitted to the facility IDT team, conduct a Patient at Risk Meeting and review appropriateness of interventions. The IDT Patient at Risk meeting will be attended by the Administrator, DON, MDS Coordinator, Director of Therapy, Social Worker and Dietary Manger. The results of these audits will be compiled monthly and present to QA. The QA committee will address any findings of non- compliance by educating individuals or using new interventions as necessary. The facilitie's system and findings will be monitored very closely to ensure that a system remains in place. Date of correction 7/08/2011	

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F 323	Continued From page 10 reflects interventions for Resident #2 and Resident #8 are needed corrective action will be taken immediately. The findings of these audits are reported immediately to the charge nurse, who in turn will call the DON. These immediate corrective actions can include but are not limited to repositioning of resident, placing a barrier such as pads or rolled up blankets to close any potentially dangerous gap(s), adjusting the side rail to a safe level and any mechanical failures reported to the Maintenance Director. The charge nurse will then inform the Administrator and/or DON. The Administrator and/or DON also reviews the side rails audits daily and will continue so for the next 30 days. They will then review them weekly for the next 60 days. Non-compliant issues will be addressed immediately by the Administrator and or DON and interventions put in place. In addition, all non-compliant findings will be addressed at monthly QA meetings. To ensure that other residents are not affected by non-complaint side rail issues, all residents with side rails will have a side rail assessment completed by the facility's MDS Coordinator on 7/08/2011. All resident care plans and Kardex were updated as of 7/08/2011. Each bed in the facility was assessed on 7/08/2011 by the Director of Maintenance to ensure that the side rails are in working condition, installed properly and do not impose an entrapment risk. The audit and assessment revealed 28 full side rails in use. Out of that 28, 8 side rails were removed and 14 changed to half rails. On 7/08/2011using the mentioned side rail audit tool, each resident was checked by the DON or Administrator to ensure his/her side rail does not impose any entrapment risk. No gaps larger than 4 inches between the	F 323		

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F 323	Continued From page 11 mattress and side rails were found, all rails were fastened correctly and tightly and no evidence of potential entrapment found. The Maintenance Director or Nursing Supervisor will check each side rail daily for the next 30 days to ensure that side rails are securely fastened and no space greater than 4 inches exist. The Maintenance Director or Nursing Supervisor will then check each side rail weekly for the next 60 days to ensure that side rails are securely fastened and no space greater than 4 inches. Any non-compliant findings will be addressed immediately with corrective actions to ensure resident safety. Further actions and assessments will be evaluated at monthly QA meetings. All nurses certified nursing assistance, housekeepers, and department managers were in serviced by the facility Administrator, Facility Administrative Manager or DON on 7/07/2011 and 7/08/2011. Any individual who has not completed this in service by 7/08/2011 will not be allowed to work until completion is achieved. The in service included: proper positioning of full side rails when head of bed is elevated, side rails locked in place, checking for space of less than four inches between mattress and bed, side rail is securely fastened to the bed, and when raising and lowering the side rail the bed functions with no risk of entrapment. Each certified nursing assistant was instructed to complete a side rail tool by auditing the residents that they are assigned before the start of duty beginning second shift 7/08/2011. After the 3rd shift on 7/08/2011 the auditing will take place at the beginning and end of each shift. Any findings during the audit process that require corrective actions by the nursing assistant will be taken	F 323		

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F 323	Continued From page 12 immediately to ensure resident safety, and these audit findings will be reported to the charge nurse. These immediate corrective actions include but are not limited to repositioning of resident, placing a barrier such as pads or rolled up blankets to close any potentially dangerous gap, adjusting the side rail to a safe level and any mechanical failures reported. The administrator is to be alerted immediately of any issues that can not be immediately resolved. The charge nurse informs the Administrator and/or DON of any issues reported. The Administrator and/or DON also reviews the side rails audits daily and will continue so for the next 30 days. They will then review them weekly for the next 60 days. Non-compliant issues will be addressed immediately by the Administrator and or DON and interventions put in place. In addition, all non-compliant findings and interventions as well as outcomes will be addressed at monthly QA meetings. To ensure that the system of preventing accidents of potential bed rail entrapment remains in place and that the facility remains in compliance; the DON or Administrator will audit daily the completed side rail tools completed by the nursing assistant daily for the first 30 days then weekly for the following 60 days. The Maintenance Director will complete an audit consisting of making sure all rails fit the bed properly and are in good working order weekly for 60 days. The Administrator will complete a report weekly of all identified issues that were non-compliant, and the corrective action, weekly. A copy of this report will be submitted to the facility IDT team, conduct a Patient at Risk Meeting and review appropriateness of	F 323		

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F 323	Continued From page 13 interventions. The IDT Patient at Risk meeting will be attended by Administrator, DON, MDS Coordinator, Director of Therapy, Social Worker and Dietary Manger. The results of these audits will be compiled monthly and present to QA&A. The QA&A committee will address any finding of non compliance by educating individuals or using new interventions as necessary. Immediate Jeopardy was removed on July 8, 2011 at 7:55 p.m. with interviews of direct care and licensed nursing staff who confirmed they received in-service training on 07/08/11 prior to reporting on duty. Interviews with nursing staff revealed awareness of the monitoring tool to be completed at the beginning and end of every shift. Nursing staff was able to state actions to be taken if side rails were not fitting properly or presented a safety hazard. Staff also related knowledge of proper positioning of full side rails when the head of the bed was elevated. All resident beds were observed while accompanied by licensed and non licensed nursing staff. Observations revealed bed rails were securely attached to the bed frames and appropriate to resident needs.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F-371 Store/Prepare/Serve –Sanitary On 7/07/2011 the facility took down the ceiling fan blades and the fan was removed on 7/25/2011 to remove the potential for future issues. The racks were cleaned on 7/08/2011.	

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to clean a ceiling fan directly over a food preparation table and food serving area and failed to clean a metal rack containing serving utensils directly over a food preparation table. The findings are: 1. On 07/05/11 at 11:42 a.m. a white ceiling fan which was positioned directly over a food preparation and food serving table in the kitchen was observed in operation. Closer observation of the ceiling fan revealed that each of the fan blades had an accumulation of a black substance on their edges and tips. Staff was observed preparing/serving foods for the lunch meal directly under the ceiling fan. On 07/06/11 at 12:15 p.m. the kitchen's ceiling fan was again observed in operation while staff was preparing/serving foods on the table directly underneath the fan. On 07/07/11 the facility's Dietary Manager turned the ceiling fan off and each of the fan blades were observed to have a black substance with a heavy dust buildup on their edges and on their tips. During an interview on 07/07/11 at 9:40 a.m. the Dietary Manager stated it was her expectation for all areas in the kitchen to be kept clean. She	F 371	An In service was held by The dietary manager for All dietary staff on 7/27/2011 In order to ensure that other areas are not affected by the same alleged deficient practice the dietary staff was in serviced on sanitary preparation and storage. The am staff was instructed to complete an audit tool daily for 30 days, then completed monthly thereafter by the Dietary Manager. Any findings on the audit tool that are not in compliance will be corrected immediately before food preparation begins. The maintenance director or his designee will be notified immediately for correction. To ensure that a system remains in place the dietary manager will audit compliance of daily audit tool completion. She will complete a weekly audit tool on equipment sanitation for 30 days. Thereafter the areas will be audited monthly using the Kitchen sanitation tool completed by the Dietary manager for monthly QA. The findings and immediate remedies will be reported to the Administrator daily. The dietary manager will prepare a report of findings weekly for 30 days then monthly thereafter. This tool will be presented to QA.	

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F 371	Continued From page 15 explained sometimes dietary staff cleaned the ceiling fan and sometimes maintenance cleaned them. She verified that cleaning of the ceiling fan was not on the kitchen's routine cleaning schedules and she was not sure when they were last cleaned. She stated it looked like dust had collected on the edges of the blades and stated they should be routinely cleaned. She further verified the ceiling fan was directly over the food preparation table and the serving line where all resident's food was served onto their plates. 2. On 07/05/11 at 11:41 a.m. a metal rack was observed sitting on top of a food preparation table with a variety of kitchen utensils hanging from the top of it. On the top right side of this metal rack, next to the serving utensils there was a gray substance hanging down from the top corner of the stand directly over the food preparation area. Staff were observed preparing foods for the lunch meal at this time. Further observations on 07/07/11 at 9:44 a.m. revealed a gray substance hanging down from the top right corner of the metal rack sitting on top of a food preparation table, next to the serving utensils and directly over the food preparation area. Staff were not observed preparing food at this time. During an interview on 07/07/11 at 9:44 a.m. the Dietary Manager confirmed the gray substance hanging down from the top right side of the rack on the food preparation table looked like dust. She explained the rack was used to hang various kitchen utensils for serving food on the tray line. The Dietary Manager stated the rack was supposed to be cleaned each week when the	F 371	The facility plans to monitor its performance to make sure that solutions are sustained and to evaluate the systems effectiveness by weekly monitors of all completed tools by the facility Administrator. The facility Administrator will also complete an audit tool weekly for 30 days of all dietary areas and equipment to ensure areas are clean and sanitary for food preparation and storage. Thereafter the Dietary manager will complete a sanitation audit and report monthly for QA. Any areas will be corrected immediately and the findings of this audit will be presented to the QA committee monthly to ensure that the system remains in effect. Correction date 7/30/2011	

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F 371	Continued From page 16 filters in the hood over the stove were cleaned. She further stated staff must have missed cleaning the rack when the hood filters were cleaned earlier on Monday of this week. She further stated equipment with dust should not be hanging over the food preparation areas.	F 371		
F 441 SS=E	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 hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F-441 Infection Control, Prevent Spread, Linens Corrective action for the alleged deficient practice of the facility failing to remove soiled gloves and wash hands during a dressing change was accomplished by counseling the employee on proper technique to prevent infection on 7/27/2011 by the DON. In order to ensure that others are not affected by the same alleged deficient practice the facility in serviced all license staff between 7/27/2011 and 7/30/2011. On 7/28/2011 the Director of Nursing observed the individual cited to ensure return demonstration was appropriate and that substantial compliance was achieved. So that others are not affected by the same alleged deficient practice The Director of Nursing in-serviced all licensed nurses and certified nursing assistants between 7/27/2011 and 7/30/2011 on hand hygiene, glove usage, and proper infection control measures .Any licensed nurse or certified nursing assistant not in attendance, were required to complete an in-service prior to being allowed to do patient care.	

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F 441	Continued From page 17 (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 observations, staff interviews, and facility record reviews, the facility staff failed to remove soiled gloves and wash hands during a dressing change for one (1) resident. (Resident #3), wear gloves or wash hands while providing incontinence care for one (1) resident (Resident #2), clean residents' skin before obtaining finger stick blood sugars for two (2) residents. (Residents #15 and #21) from a total sample of ten (10) residents observed for care. In addition the facility failed to clean equipment between resident uses. The findings are: 1. Resident #3 was readmitted to the facility with diagnoses including Ischemic Heart Disease, Chronic Obstructive Pulmonary Disease and Diabetes. Review of the most recent Minimum Data Set (MDS) dated 05/10/11 indicated Resident #2 had severely impaired cognitive skills for daily decision making and required total assistance with bed mobility, bathing and toilet use. The MDS further indicated Resident #3 was at risk for pressure ulcers with one Stage II pressure ulcer present. Review of a physician's order dated 06/28/11 to clean left hip wound with normal saline and apply	F 441	The systematic changes made to ensure that the facility includes an infection control plan to prevent the spread of infection include a daily monitoring tool completed by the Director of Nursing, Administrator, or Weekend supervisor to be completed daily for 30 days then monthly thereafter. Any non- compliance is corrected immediately and reported to the Administrator. In order to monitor the facility's performance the Administrator will complete an audit weekly of the daily compliance tools concerning glove usage and proper infection control measures The MDS Nurse or DON will complete an observation tool to randomly select a licensed staff member to document compliance. This will be completed weekly for 30 days then monthly thereafter. Findings from all audits will be corrected immediately and will be presented to the QA committee monthly. Any non-compliant staff member will be re-educated on the proper technique and monitored daily until compliance achieved. The QA committee will evaluate all reports to ensure that the system remains in effect. Date of correction 7/30/2011	

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F 441	Continued From page 18 an antiseptic solution wet to dry dressing daily. On 07/06/11 at 4:15 p.m., Licensed Nurse (LN) #3 was observed providing wound care to Resident #3. LN #3 gathered supplies, washed her hands, gloved and removed the soiled dressing. Without changing gloves or washing her hands, LN#3 cleansed the wound with normal saline, applied the wet to dry dressing and taped the dressing in place. On 07/06/11 at 4:35 p.m. LN #3 was interviewed and acknowledged she did not change gloves or wash her hands after removing the old dressing and before cleaning and applying a clean dressing to the wound. LN #3 added she should have taken her gloves off between removing the old dressing and before cleaning and redressing the wound. An interview on 07/08/11 at 4:05 p.m. with the Director of Nursing (DON) revealed it was her expectation for licensed nurses to wash their hands prior to the procedure, gather supplies, glove, remove old dressing, remove gloves, wash hands, re-glove and proceed with wound care. 2. An observation of the 300 Hall shower room on 07/06/11 at 10:05 a.m. revealed a shower chair located just outside the shower stall. A one (1) by two (2) inch area of brown colored matter was observed on the chair frame below the seat. Subsequent observations on 07/06/11 at 2:00 p.m. and 4:30 p.m. revealed brown colored matter remained on the shower chair frame. An observation on 07/07/11 at 8:45 a.m. revealed the shower chair was located in the shower stall, wet with brown colored matter on the chair frame.	F 441	Corrective action for the alleged deficient practice of the facility failing to clean the resident's skin before obtaining a finger stick for blood sugars on resident # 15 and # 21 was obtained by counseling the licensed staff members responsible on proper technique and policy. Completion date 7/27/2011. In order to ensure that others are not affected by the same alleged deficient practice the DON required that the two nurses complete a return demonstration on proper technique. She also in-serviced all licensed staff on policy and procedure and appropriate technique between 7/27/2011 and 07/30/2011. The systematic change made to ensure that the facility includes an infection control program to prevent the spread of infection concerning blood glucose checks includes a monitoring tool with this area observed daily by the Director of Nursing or Week end supervisor. The audit will be completed daily for 30 days then weekly for 3 months. Thereafter it will be audited using the monthly infection control audit tool. Any non-compliance will be corrected immediately and the staff member retrained on technique.	

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F 441	Continued From page 19 An interview with the housekeeping supervisor on 07/07/11 at 9:00 AM revealed housekeeping provided a deep pressure cleaning with a degreaser agent in the shower rooms and on shower chairs three times a week. He also indicated housekeeping staff provided daily cleaning of resident areas including the shower rooms and shower chairs and more frequently if needed. During this interview, the housekeeping supervisor observed the presence of a brown colored matter on the shower chair. He further revealed it is the responsibility of the nursing assistants (NA) to clean the shower chairs with a disinfectant spray between residents' use. On 07/07/11 at 9:15 am NA #1 was interviewed and indicated NAs should clean the shower chair with disinfectant spray between uses for each resident. NA #1 acknowledged the shower chair had been used throughout the day. An interview on 07/08/11 at 4:05 PM with the DON revealed the NAs were expected to spray and wipe down the shower chairs with a disinfectant spray between residents' use A review of an undated facility policy for Incontinence Care stated to put on gloves before providing perineal care. 3. Resident #2 was admitted on 01/11/05 with diagnoses including Stroke, Left Sided Paralysis, Aphasia, Abnormal Posture, and Dementia. A review of the annual Minimum Data Set (MDS) dated 12/20/10 revealed the resident had short term and long term memory problems and severe impairment in cognition. The MDS also indicated Resident #2 required extensive assistance to	F 441	The result of the findings and corrective action will be reported daily to the Administrator for 30 days, and a report will be complied monthly for QA. Thereafter this will be monitored monthly by the DON using an Infection audit tool findings will be reported to QA for evaluation and to ensure that the system remains In place.. Date of Completion 7/31/2011 Corrective action for the alleged deficient practice of the facilities failure to clean equipment in between resident uses was obtained by inspecting and cleaning all shower equipment on 7/08/2011.By the Housekeeping Director To ensure that others are not affected by the same alleged deficient practice the facility staff was in serviced on facility policy and proper cleaning of equipment. In services were held between 7/27/2011 and 7/30/2011 by the DON.	

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F 441	Continued From page 20 move to and from a lying position in bed, turn from side to side, and position her body in bed. A review of the Plan of Care for activities of daily living dated 12/23/10 for Resident #2 indicated interventions to check resident frequently for incontinence and provide peri-care after each episode. A review of the Plan of Care for Resident #2 at risk for skin breakdown due to immobility and incontinence dated 12/23/10 indicated interventions to keep resident clean and dry. During an observation of incontinence care on 07/06/11 at 9:28 a.m. for Resident #2, NA #7 washed her hands and put gloves on. NA #8 was standing on the opposite side of the resident's bed and did not wash her hands or put gloves on. NA #8 assisted with turning the resident while NA #7 removed a soiled brief and bathed her. The soiled linens were pushed up under Resident #2 and NA #8 rolled the soiled linens down toward the foot of the bed with her bare hands and placed them into a plastic bag. NA #7 put clothing on Resident #2 and NA #8 took a gait belt from around her waist and assisted NA #7 with transferring the resident to a wheelchair. NA #8 took the gait belt off of Resident #2, placed her hand on the door handle of the room, opened the door and walked out into the hallway. During an interview on 07/06/11 at 9:52 a.m. NA #8 verified she rolled the soiled linens down from the top of the bed. She stated she did not think she needed to wear gloves or wash her hands because she did not touch bodily fluids.	F 441	To ensure that the facility has implemented a systematic change to ensure that all equipment is cleaned properly an audit tool was implemented for daily usage by the NA. An audit tool will be completed daily for 30 days by the Director of Nursing or weekend Supervisor . Thereafter, the DON will complete an Infection Control audit tool monthly, to monitor this areas compliance. Any non-compliance is corrected immediately and reported to the Administrator immediately. The Administrator will compile a report of all findings and interventions to discuss with the QA committee monthly for 3 months. Thereafter the DON will compile an Infection Control audit discussed monthly during QA. To ensure that the system remains in place. Date of correction 7/31/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING ____ B. WING ____	C 07/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 21 During an interview on 07/06/11 at 9:57 a.m. NA #7 stated she did not know why NA #8 did not wear gloves while she assisted with incontinence care. NA #7 stated she always wore gloves when she assisted with incontinence care because "you don't know what you're going to touch." During an interview on 07/08/11 at 4:30 p.m. the Director of Nursing (DON) stated it was her expectation that Nursing Assistants should always wash their hands and wear gloves when providing incontinence care and when assisting with incontinence care. She stated LN #8 should have washed her hands and put on gloves before assisting with incontinence care and she should have washed her hands before she handled the gait belt and door handle to Resident #2's room. 4. Resident # 15 was admitted to the facility 12/15/10 with diagnoses including Diabetes Mellitus and Stroke. a. An observation was conducted on 07/05/11 at 4:35 p.m. of Licensed Nurse (LN) #2 obtaining a finger stick blood sugar (FSBS) from Resident #15. LN #2 was observed puncturing the resident's finger, obtaining blood sample, and then wiping the puncture site with an alcohol swab. An interview with LN #2 on 07/05/11 at 4:47 p.m. revealed her common practice was not to clean the puncture site prior to sticking a finger for FSBS. She stated she was taught this procedure in nursing school. b. An observation was conducted on 07/06/11 at 11:55 a.m. of LN #3 obtaining a FSBS from	F 441		

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F 441	Continued From page 22 Resident #15. LN #3 was observed puncturing the resident's finger, obtaining blood sample, and then wiping the puncture site with an alcohol swab. An interview with LN #3 on 07/06/11 at 12:05 p.m. revealed her common practice was not to clean the puncture site prior to sticking a finger for FSBS. She stated she was taught this procedure when she did clinical practice during nursing training at the local acute care facility in 2007. An interview with the Director of Nursing (DON) on 07/08/11 at 10:35 a.m. revealed it was her expectation for nurses to clean puncture sites before obtaining FSBS. She added she felt this was best practice for long term care. 5. Resident #21 was admitted to the facility 01/07/10 with diagnoses including Diabetes Mellitus and Stroke. a. An observation was conducted on 07/05 11 at 4:44 p.m. of Licensed Nurse (LN) #2 obtaining a finger stick blood sugar (FSBS) from Resident #21. LN #2 was observed puncturing the resident's finger, obtaining blood sample, and then wiping the puncture site with an alcohol swab. An interview with LN #2 on 07/05/11 at 4:47 p.m. revealed her common practice was not to clean the puncture site prior to sticking a finger for FSBS. She stated she was taught this procedure in nursing school. b. An observation was conducted on 07/06/11 at 12:00 p.m. of LN #3 obtaining a FSBS from	F 441		

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F 441	Continued From page 23 Resident #21. LN #3 was observed puncturing the resident's finger, obtaining blood sample, and then wiping the puncture site with an alcohol swab. An interview with LN #3 on 07/06/11 at 12:05 p.m. revealed her common practice was not to clean the puncture site prior to sticking a finger for FSBS. She stated she was taught this procedure when she did clinical practice during nursing training at the local acute care facility in 2007. An interview with the Director of Nursing (DON) on 07/08/11 at 10:35 a.m. revealed it was her expectation for nurses to clean puncture sites before obtaining FSBSs. She added she felt this was best practice for long term care.	F 441		