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
	345264	A. BUILDING _____ B. WING _____	C 09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

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F 000	INITIAL COMMENTS No deficiencies were cited as result of this complaint investigation. Event ID# Q4EQ11.	F 000	Preparation and submission of this Plan of Correction does not constitute an agreement of admission by Stanley Total Living Center of the truth to the facts alleged or conclusions set forth in the CMS-2567. This Plan of Correction is written in response to the Statement of Deficiencies and demonstrates our good faith and desire to improve quality care and services rendered to our residents—It is submitted as required by Federal and State Law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225	Appropriate in house investigations were completed for Res. #13 and Res. #22 at the time of the allegation(s) and both were found to be unsubstantiated. The 24 hour and 5 day working reports were submitted to the appropriate state agency noting these findings. All allegations of abuse reported to the DON since the last recertification survey were reviewed for completion of	10/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Kelleher — TITLE: Administrator — (X6) DATE: 10/13/11

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.

OCT 21 2011

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F 225	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility record review, the facility failed to report an allegation of abuse to the state agency within twenty-four hours and failed to report results of the investigation to the state agency within five days for two (2) of three (3) abuse investigations (Residents #13 and 22). The findings are: 1. Resident #13 was admitted to the facility with diagnoses of osteoarthritis and adult failure to thrive. The most recent Minimum Data Set dated 08/21/11 revealed Resident #13 had moderate impairment of cognition. Review of a facility incident report on 09/16/11 completed by a licensed nurse revealed that Resident #13 alleged that Nursing Assistant (NA) #7 had grabbed her legs and thrown them onto the bed during a transfer. The investigation noted that the resident had a bruise on her right lower leg. An interview with the Director of Nursing (DON) on 09/22/11 at 6:55 p.m. revealed that when she was made aware of the allegation, she suspended NA #7 and began an investigation of potential abuse. The DON stated she did not file reports with the state agency because she was unable to substantiate abuse.	F 225	report forms. The required reports were filed for any investigations that were substantiated by the DON at the time of the incident. Any found to be unsubstantiated through an in house investigation but missing required state reporting forms were completed and submitted as required. The policy & procedure for abuse was revised to ensure that all allegations of abuse/neglect are reported using the required 24 hour and 5 day working report forms to the appropriate state agency. All staff will be educated on this policy revision by the SDC on 10/20/11. A written format of all requirements for any abuse/neglect investigation will be followed by the DON for any and all allegations. This format will in clued date/time each step, including the filing of reports, has been completed. The Administrator will review each investigation for the	10/11/11 10/20/11 10/20/11

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F 225	Continued From page 2 2. Resident #22 was admitted to the facility with diagnoses of dementia and Parkinson's Disease. The most recent Minimum Data Set dated 08/21/11 revealed Resident #22 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. Review of a facility abuse investigation revealed that on 03/07/11 Nursing Assistant (NA) #6 alleged that NA #5 struck Resident #13 on her hand. An interview with the Director of Nursing on 09/22/11 at 6:55 p.m. revealed that when she was made aware of the allegation, she suspended NA #5 and began an investigation of potential abuse. The DON stated she did not file reports with the state agency because she was unable to substantiate abuse.	F 225	completion of each step in a timely manner as required by law and report all allegations of abuse (and the outcome of each investigation) to the QA&A Committee monthly for continued compliance.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep the hallway ceiling and ceiling vents clean on one (1) of three (3) hallways (500 hallway). The findings are:	F 253	No residents were noted to have any adverse effects or harm. All ceiling vent, air returns, and sprinkler units on the 500 unit were cleaned thoroughly. Although there were no noted concerns on the other hallways, 100 and 400 unit ceiling vents, air returns, and sprinkler units were cleaned thoroughly.	9/27/11 10/6/11

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F 253	Continued From page 3 On 09/20/11 at 11:15 a.m. a general tour of the 500 hallway revealed an accumulation of dust and black grime on thirteen (13) of fourteen (14) heating and air conditioning ceiling vents and the surrounding ceiling area, an accumulation of dust and black grime on one ceiling return air vent, and dust hanging from ceiling sprinkler units. On 09/22/11 at 2:00 p.m. a second observation of the hallway ceiling on the 500 hall revealed the same conditions as above. On 09/22/11 at the Environmental Services Director was interviewed. He stated that his department was responsible for cleaning the ceilings in resident rooms but not the ceilings in the hallways. He stated hallway ceilings were the responsibility of the Maintenance Department. On 09/22/11 at 3:15 p.m. the Maintenance Director was interviewed. He stated that cleaning of hallway ceilings was the responsibility of the Environmental Services Department. On 09/22/11 at 3:30 p.m. the Administrator toured the 500 hallway and stated that the heating and air conditioning ceiling vents, the ceiling return air vent, and the ceiling sprinkler units all needed to be cleaned. She stated that cleaning the hallway ceilings and ceiling structures was the responsibility of the Environmental Services Department and that she would see that the ceiling was cleaned.	F 253	The hallway ceiling vents, air returns, and sprinkler units will be cleaned monthly and as needed by Housekeeping as assigned by the Environmental Services Director. This routine assignment will be noted on a specific assignment sheet and signed by the designated staff member upon completion. Housekeeping staff will be educated on this procedure and expectations by the Environmental Services Director on 10/20/11. The Environmental Services Director will randomly inspect ceiling structures on a weekly basis for cleanliness and will correct concerns immediately. The Administrator will randomly inspect ceilings and ceiling structures monthly and report any concerns to the QA&A Committee for continued compliance.	10/20/11 10/20/11
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		

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F 312	Continued From page 4 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, facility and medical record reviews, and staff interviews the facility failed to provide appropriate incontinent care and/or nail care for three (3) of six (6) sampled residents dependent on staff for activities of daily living and personal hygiene. (Residents # 9, #10, and #3). The findings are: 1. An undated document, provided by the facility, titled "PERINEAL CARE" read in part: "PURPOSE - 1. To cleanse the perineum. 2. To prevent infection and odor." Procedure instructions included washing the perineum (genital) area "moving from front to back, using a clean area of the washcloth or clean washcloth for each stroke." a. Resident #10 was admitted to the facility with diagnoses including Alzheimer's, Dementia, Chronic Kidney Disease, and Renal Failure. On the most recent Minimum Data Set (MDS), a quarterly dated 07/17/11, Resident #10 was assessed as having short and long term memory problems, severely impaired cognitive skills for daily decision making, frequent bladder and bowel incontinence, and as requiring extensive assistance with toileting and personal hygiene. On the 07/26/11 plan of care Resident #10 was	F 312	**1a & 1b** NAI and NAII were counseled and re-educated on proper procedures and expectations for incontinent care by the SDC for all residents but specifically regarding Res. #9 and Res. #10. The SDC and Nursing Supervisors will observe nursing assistants on each shift/unit over a period of (1) week at random for the provision of incontinent care to ensure no other residents have been affected by improper technique. Any concerns will be immediately addressed and corrected. All nursing staff will be in-serviced by the SDC on proper technique for the provision of incontinent care. This training will be provided to all nursing staff upon initial orientation and at least annually with the employee's performance evaluation by the SDC.	10/5/11 10/19/11 10/20/11

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F 312	Continued From page 5 identified as requiring assistance with all activities of daily living (ADLs) due to impaired cognition and at risk for skin breakdown due to incontinence. Care plan interventions included staff to provide all personal hygiene and incontinent care as needed. On 09/22/11 at 9:45 AM Nursing Assistant (NA) #1 and NA #2 were observed providing incontinent care for Resident #10. Resident #10's soiled brief was removed, the resident was positioned on her back on the bed, and NA #1 proceeded to provide incontinent care. During the process NA #1 cleaned the left and right groin area and proceeded to the perineal area, cleansing with six (6) short and fast back to front strokes using the same area of the cloth. NA #1 changed to a clean area of the cloth and continued cleansing the perineal area washing two (2) strokes from back to front followed by one stroke front to back without changing to a clean area of the cloth. After cleansing the perineal area NA #1 completed incontinent care, cleansing the rectal area washing front to back using clean areas of the cloth with each stroke. On 09/22/11 at 2:30 PM an interview was conducted with NA #1 and NA #2. The interview revealed NA staff were trained to cleanse residents' perineal area by washing front to back using a clean area of the cloth with each stroke. NA #1 stated Resident #9's perineal area should have been cleansed front to back using a clean area of the cloth each time. On 09/22/11 at 5:30 PM an interview was conducted with the facility Administrator and Director of Nursing (DON). The interview	F 312	A QA monitoring tool will be utilized by shift supervisors to ensure proper technique for incontinent care is being followed. This monitoring will be completed for each shift (3) times per week for the 1st month, (2) times per week for the 2nd month, and finally (1) time per week for the 3rd month. Variances will be corrected immediately upon observation and continued concerns with the same employee will be reported to the DON for further corrective action. The DON will review monitoring tools and report findings to the QA&A Committee—compliance will be monitored for total of (3) months or until resolved. Continued compliance will be monitored through random observation through the QA&A program.	10/20/11

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F 312	Continued From page 6 revealed during new employee orientation, annually, and periodically throughout the year, NA staff received training regarding proper incontinent care. The DON stated NA staff were trained and expected to cleanse the perineal area from front to back using a clean cloth or area with each stoke. b. Resident #9 was admitted to the facility with diagnoses including Diverticulosis and Dementia. On the most recent Minimum Data Set (MDS), a quarterly dated 09/11/11, Resident #9 was assessed as having short and long term memory problems, moderately impaired cognitive skills for daily decision making, frequent bladder and bowel incontinence, and as requiring extensive assistance with toileting and personal hygiene. On the 09/20/11 plan of care Resident #9 was identified as requiring assistance with all activities of daily living (ADLs) due to impaired cognition and at risk for skin breakdown due to incontinence. Care plan intervention included staff assistance with personal hygiene and incontinent care as needed. On 09/22/11 at 9:20 AM Nursing Assistant (NA) #1 and NA #2 were observed toileting and providing incontinent care for Resident #9. During the observation Resident #9's soiled brief was removed and the resident was placed on the toilet. After having a bowel movement NA #2 assisted Resident #9 to a standing position while NA #1 provided incontinent care. During the process NA #1 cleansed the left and right groin area and proceeded to the perineal area, cleansing with three (3) back to front strokes using the same area of the cloth. NA #1 changed	F 312		

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F 312	Continued From page 7 to a clean area of the cloth and continued cleansing the perineal area washing one stroke from front to back, followed by two (2) strokes from back to front without changing to a clean area of the cloth. After cleansing the perineal area NA #1 completed incontinent care, cleansing the rectal area washing front to back using clean areas of the cloth with each stroke. On 09/22/11 at 2:30 PM an interview was conducted with NA #1 and NA #2. The interview revealed NA staff were trained to cleanse residents' perineal area by washing front to back using a clean area of the cloth with each stroke. NA #1 stated Resident #9's perineal area should have been cleansed front to back using a clean area of the cloth each time. On 09/22/11 at 5:30 PM an interview was conducted with the facility Administrator and Director of Nursing (DON). The interview revealed during new employee orientation, annually, and periodically throughout the year NA staff received training regarding proper incontinent care. The DON stated NA staff were trained and expected to cleanse the perineal area from front to back using a clean cloth or area with each stoke. 2. a. Resident #10 was admitted to the facility with diagnoses including Alzheimer's and Dementia. On the most recent Minimum Data Set (MDS), a quarterly dated 07/17/11, Resident #10 was assessed as having short and long term memory problems, severely impaired cognitive skills for daily decision making, and requiring extensive assistance with dressing, bathing, and personal hygiene.	F 312	**2a & 2b** Appropriate nail care was provided for Res. #3 & Res. #10 immediately. Nurse Managers completed an auditing tool on all residents' nails—care needs were addressed Immediately.	9/22/11 9/29/11

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F 312	Continued From page 8 On the 07/26/11 plan of care Resident #10 was identified as requiring assistance with all activities of daily living (ADLs) due to impaired cognition and at risk for skin breakdown. Care plan interventions included staff to provide all personal hygiene and two (2) showers weekly. Review of the September 2011 monthly bath report, utilized by the facility for documenting residents' baths/showers, revealed Resident #10 was bathed/showered on the mornings of 09/20/11 and 09/22/11. Review of Nursing Assistant (NA) computer data entries, utilized for documenting ADLs care, revealed Resident #10 was provided personal hygiene daily on 09/20/11, 09/21/11, and 09/22/11. On 09/20/11 at 11:20 AM, during initial tour, Resident #10 was observed in the hallway with fingernails extending approximately one eighth (1/8) inch beyond the tip of each finger on the left and right hand. All fingernails were observed with small to moderate amounts of dark brown/black debris under each nail. Additional observations of Resident #10's fingernails with debris and extending beyond the finger tips included: 09/20/11 at 12:40 PM 09/21/11 at 9:15 AM, 9:25 AM, 12:30 - 1:00 PM, 4:40 PM, and 5:30 PM 09/22/11 at 8:15 AM, 9:35 AM, and 12:30 PM During an interview, 09/22/11 at 2:30 PM, NA #1 and NA #2, assigned to Resident #10, observed the resident's nails and confirmed that trimming and cleaning was needed. The interview revealed nail care was to be completed by the	F 312	All nursing staff will be in-serviced by the SDC on the proper technique for the provision of nail care. . This training will be provided to all nursing staff upon initial orientation and at least annually with the employee's performance evaluation by the SDC. A QA monitoring tool will be utilized by shift supervisors to ensure proper nail care is being provided. This monitoring will be completed for each shift (3) times per week for the 1st month, (2) times per week for the 2nd month, and finally (1) time per week for the 3rd month. Variances will be corrected immediately upon observation and continued concerns with the same employee will be reported to the DON for further corrective action. The DON will review monitoring tools and report findings to the QA&A Committee—compliance will be monitored for total of (3) months or until resolved.	10/20/11 10/20/11

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F 312	Continued From page 9 shower person, NA #3, twice weekly during baths/showers. NA #1 stated Resident #10 was bathed/showered by NA #3 on the morning of 09/22/11 and nail care should have been completed. The interview further revealed all NA staff were responsible for monitoring residents' nails during daily ADL care and providing nail care as needed. NA #1 and NA #2 stated attempts were made to observe residents nails during care and throughout the day, however, specific nail checks were not completed on a daily basis. NA #1 and NA #2 stated fingernail care was not provided during their shifts on 09/20/11, 09/21/11, or 09/22/11. NA #3 was not available for interview. During an interview, 09/22/11 at 3:15 PM, Licensed Nurse (LN) #1 confirmed Resident #10's nails were in need of cleaning and trimming. The interview further revealed all NA staff were responsible for checking residents' nails during ADL care, providing nail care as needed, and/or notifying LN staff if nail care could not be provided. LN #1 stated prior to today she had not observed and was unaware that Resident #10's nails were in need of cleaning and trimming. On 09/22/11 at 5:30 PM an interview was conducted with the Director of Nursing (DON). The DON stated NA staff were responsible for and expected to provide nail care during showers and as part of ADL care when needed. The interview further revealed LN staff were responsible for monitoring residents' nails and delivery of ADL care. b. Resident #3 was admitted to the facility with	F 312	Continued compliance will be monitored through random observation through the QA&A program.	

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F 312	Continued From page 10 diagnoses which included Alzheimer's Disease. On the most recent Minimum Data Set dated 08/14/11, Resident #3 was assessed to have short and long term memory problems and severely impaired cognitive skills for daily decision making. He required extensive assistance from staff for most activities of daily living (ADL), including personal hygiene. On the resident's most recent care plan, revised 08/23/11, Resident #3 was identified as requiring assistance with all ADL including personal hygiene. One intervention for this problem was to provide all personal hygiene care routinely and as needed to include trimming and cleaning of finger and toenails. On 09/20/11 at 11:56 AM Resident #3 was observed in bed. The fingers of both hands were observed to have black matter beneath the nails, with the three middle fingers of the right hand having the heaviest accumulation of black matter. On 09/20/11 at 5:15 PM Resident #3 was observed in his wheelchair at a table in the dining room. The resident was being fed by an aide, but the resident assisted by feeding himself finger foods. He was also observed to rest his left hand on his plate with his fingers touching his beans. The fingers of both hands were again observed to have black matter beneath them. On 09/21/11 at 10:08 AM Resident #3 was observed up in his wheelchair in his room. His nails were again observed to have black matter beneath them on both hands. On 09/21/11 at 12:56 PM Resident #3 was	F 312		

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F 312	Continued From page 11 observed in his wheelchair at a table in the dining room. The resident was being fed by an aide, but the resident assisted by feeding himself finger foods. The resident's hands were observed to have black matter beneath the nails. On 09/21/11 at 5:30 PM Licensed Nurse (LN) #2 was interviewed. She stated she expected nursing assistants (NA) to check a resident's fingernails as part of assisting with ADL and to clean nails whenever they were dirty. She stated that if Resident #3's nails were dirty, an NA should have seen this when washing his hands before meals. On 09/21/11 at 5:40 PM the Director of Nursing was interviewed. She stated she expected NAs to check nails as part of ADL. She stated she would expect that an NA would have seen that Resident #3's nails were dirty and cleaned them when his hands were washed before meals.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	NA#5 was counseled and re-educated on proper technique for catheter care of a male resident. (5) residents with catheters had the potential for being affected by improper technique. The SDC and unit/shift supervisors observed nursing staff over a period of (1) week on all (3) shifts for the provision of catheter care. Any concerns were immediately identified and corrected.	9/29/11 10/19/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	C 09/22/2011

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F 315	Continued From page 12 Based on observations, staff interviews, and medical record review, the facility failed to ensure that staff used proper technique to prevent infection during incontinence care for one (1) or two (2) residents (Resident #5). The findings are: Resident #5 was admitted to the facility with diagnoses of Alzheimer's Disease, stage 3 pressure ulcer, and perforated intestine, among others. The resident was admitted with an indwelling urinary catheter. The latest Minimum Data Set (MDS) dated 09/16/11 revealed the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. The MDS further revealed the resident required extensive to total assistance with most activities of daily living, including extensive assistance with hygiene. An interim care plan for the resident revealed that the indwelling urinary catheter was a problem to be addressed according to facility procedures. Review of physician orders revealed an order dated 09/09/11 for catheter care to be performed three times a day on each shift. On 09/21/11 at 10:46 AM Nursing Assistants (NA) #4 and #5 were observed performing routine catheter care for Resident #5. NA #5 washed the resident's catheter with a soapy washcloth by washing away from the resident's body. The resident was observed to be uncircumcised, and NA #5 did not retract his foreskin and clean the catheter beneath it. On 09/21/11 at 11:08 AM, NA #5 was interviewed. She stated she should have	F 315	The Policy/Procedure for catheter care was revised to include specific steps for both male and female care. All nursing staff will be In-serviced on this procedure by the SDC on 10/20/11. . This training will be provided to all nursing staff upon initial orientation and at least annually with the employee's performance evaluation by the SDC. A QA monitoring tool will be utilized by the SDC who will randomly select (1) staff member weekly for (3) months on alternating shifts/units for the observation of catheter care. Concerns will be addressed immediately—continued concerns with the same employee will be referred to the DON for further counseling as necessary. The DON will review monitoring tools and report findings to the QA&A Committee—compliance will be monitored for total of (3) months or until resolved.	10/20/11 10/20/11

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 315	Continued From page 13 retracted the resident's foreskin to clean the catheter beneath it as she had been taught to do, in order to minimize the chance of infection, but she forgot to do it. On 09/21/11 at 11:18 AM, Licensed Nurse (LN) #3 was interviewed. She stated she expected NAs performing catheter care on an uncircumcised resident to retract the foreskin and clean the catheter beneath it right up to the meatus, cleaning away from the body. On 09/21/11 at 11:25 AM, the Director of Nursing was interviewed. She stated she expected NAs to retract the foreskin on an uncircumcised resident with a catheter and clean beneath the foreskin up to the meatus, cleaning away from the body, in order to prevent urinary tract infection.	F 315	Continued compliance will be monitored through random observation through the QA&A program. No residents were noted to have any adverse effects or harm related to hot water temperatures in hand sinks	9/22/11
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility record review, the facility failed to ensure water temperatures in resident living areas did not exceed 118 degrees Fahrenheit on two (2) of three (3) halls.	F 323	All residents on (2) of (3) units had the potential of being affected by hot water temperatures in hand sinks. New thermometers were purchased on 9/26/11, calibrated, and put into use on 9/27/11. All hand sinks throughout the facility were checked over a period of (2) days with adjustments made as necessary. Random hand sinks were then audited over a period of (2) weeks with adjustments continuing as needed.	10/19/11

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F 323	Continued From page 14 The findings are: During an initial tour of the facility on 09/20/11, water temperatures were checked in hand sinks on all halls of the facility. Two thermometers were calibrated in a cup of water and ice and recorded temperatures between 32 and 34 degrees Fahrenheit (F). The following results were recorded: Room 517 129 degrees F at 12:55 PM Room 514 118 degrees F at 12:55 PM Room 505 118 degrees F at 12:55 PM Room 527 130 degrees F at 12:57 PM Room 527 127 degrees F at 1:05 PM Room 141 121 degrees F at 1:10 PM At 1:13 PM, the Maintenance Director stated a nurse had reported to him the water felt hotter than usual in the sinks of some rooms. He stated he checked sink water temperatures in room 517 and room 519 and they were approximately 121 degrees F, so he adjusted the water mixing valve to bring the overall temperature of the water down. The Maintenance Director was observed to check the water temperature in the sink of room 527 with a calibrated thermometer at that time and he recorded 106 degrees F. Other results were recorded with calibrated thermometers: Room 138 121 degrees F at 1:15 PM Room 134 118 degrees F at 1:15 PM At 1:17 PM the Maintenance Director re-checked room 517 and recorded 90 degrees F.	F 323	The policy/procedure for checking water temperatures was revised to include daily random temperature checks by maintenance to include (5) different rooms on both 100 and 500 units and (2) different rooms on 400 unit as well as all bathing areas. Any temperature over 118 degrees will be immediately reported to the Maintenance Director and the Administrator. Adjustments will be made accordingly and the temperature will be rechecked 15 minutes later—this will continue every 15 minutes until the water temperature is below 118 degrees. If this occurs in any bathing area, all baths will be stopped immediately and not allowed to resume until the water temperature is safe.	10/20/11

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 323	Continued From page 15 At 2:15 PM the Maintenance Director checked room 146 and recorded 125 degrees F. As he let the temperature continue to run over a period of approximately one minute, the temperature steadily dropped from 125 degrees F to 108 degrees F, where it stabilized. The Maintenance Director was interviewed at that time. He reported that water temperatures in resident rooms were checked daily. He stated that some rooms had temperatures which initially spiked to approximately 120 degrees F then steadily dropped over a minute or less and stabilized around 107 to 108 degrees F. He stated his maintenance crew had reported this spike to him and he told them to let him know if it did not consistently drop back down. The Maintenance Director stated he thought the water standing in the insulated copper pipes in the attic heated up in the summer and needed to be bled off for a few seconds until lower temperature circulating water replaced it. The Maintenance Director provided daily water temperature monitoring records for the past three months which revealed no dangerous temperatures recorded. The records indicated the same rooms on each hall were checked each day. On 09/21/11 at 2:32 PM Maintenance Worker #1 was interviewed. He stated that when he performed daily water temperature monitoring, he checked the same rooms on each hall, one close to the water heater, and one distant from it, usually at the same time each day just after lunch. He stated for the past few summer months the temperatures would sometimes spike up initially and then drop steadily over approximately a minute and stabilize into a safe range. He	F 323	The Maintenance Director will randomly audit (20) hand sinks throughout the building monthly and report all findings to the QA&A Committee for (3) months or until resolved. Continued compliance will be monitored through random checks through the QA&A program.	10/20/11

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F 323	Continued From page 16 stated he thought this was because the water gained temperature standing in the insulated copper pipes when the attic was hot. He stated he had informed the Maintenance Director of the temperature spiking problem, and the Maintenance Director had told the crew to let the water run until the temperature stabilized. The maintenance worker stated that the temperature he recorded in the temperature monitoring log was the final lower temperature it stabilized to. On 09/21/11 at 5:56 PM the Administrator was interviewed. She stated she routinely reviewed the water temperature monitoring log and had never seen unsafe temperatures. She stated the first time she had heard about a spike in temperatures was yesterday. She stated her expectation was that she would be made aware of any problem with water temperatures. She stated water temperatures in resident sinks should not be that high even for a minute.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329	Resident # 11 was discharged home as planned from the facility on 9/21/11 due to meeting the goals for short-term rehabilitation. Discharge teaching included the use of Tylenol as ordered (650mg every 4 hours as needed for pain)—the Vicodin orders were discontinued by the physician prior to discharged therefore drastically decreasing the potential for exceeding the daily maximum dosage at home.	9/21/11

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

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F 329	Continued From page 17 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 medical record review and staff interviews, the facility failed to ensure acetaminophen was not given beyond the recommended 4000 milligram/day for one (1) of nine (9) sampled residents receiving acetaminophen (Resident #11). The findings are: Resident #11 was admitted to the facility with diagnoses that included aftercare from a fracture. Admission physician orders included Tylenol (acetaminophen) 650 milligrams (mg) every four hours as needed (PRN). If taken every four hours PRN this would provide a total of 3900 mg of acetaminophen in a 24 hour period. On 08/02/11 physician orders were written for one Vicodin 5/500 (5mg hydrocodone and 500 mg acetaminophen) every four hours PRN for mild pain or two tablets every four hours for severe pain. If taken as ordered this would provide 3000 - 6000 mg of acetaminophen in addition to the 3900 mg (from Tylenol) for potential ingestion of	F 329	The QA Nurse completed an audit of all residents currently receiving Acetaminophen products for the potential of exceeding the maximum daily dosage. Any resident of concern was referred to the primary physician/PA for further review and orders were changed as needed to eliminate this potential. The Pharmacy Consultant also reviewed all residents with the potential concern and made recommendations as necessary. Standing orders for the use of Acetaminophen will be changed from 650mg every (4) hours to every (6) hours to decrease the potential for exceeding the maximum daily dosage. The primary physician and/or PA will also review each resident routinely as any orders are written for Acetaminophen to further decrease the potential. Nursing staff will be in-serviced on their role in observing all Acetaminophen orders for the potential of exceeding the daily maximum dosage, especially when PRN orders are added.	10/20/11 10/20/11

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F 329	Continued From page 18 6900 - 9900 mg of acetaminophen during a 24 hour period. On 08/10/11 the physician wrote orders to discontinue the two Vicodin every four hours PRN and replaced the order with scheduled Vicodin two tablets three times daily for a total of 3000 mg of acetaminophen if taken as ordered. The 3000 mg of scheduled Vicodin in addition to 3900 mg from PRN Tylenol and 3000 mg from PRN Vicodin would result in potential ingestion of 6900 mg - 9900 mg of acetaminophen during a 24 hour period. On 08/24/11 physician orders were written to discontinue the scheduled Vicodin two tablets three times daily and replaced the order with one tablet to be administered three times daily for a total of 1500 mg. The order also included instructions to continue Vicodin one tablet every four hours PRN. The 1500 mg of scheduled Vicodin in addition to 3900 mg from PRN Tylenol and 3000 mg from PRN Vicodin would result in potential ingestion of 6900 mg - 8400 mg of acetaminophen during a 24 hour period. Review of all Medication Administration Records (MARs) for Resident #11 revealed on 08/12/11 the resident received a total of 4150 mg acetaminophen as follows: Vicodin 5/500 two tablets three times a day were signed as given (3000 mg); two 325 mg (650 mg) tablets of Tylenol were signed as given PRN, and one tablet Vicodin 5/500 (500 mg) was signed as given PRN. On 9/22/11 at 1:00 PM a licensed nurse that routinely worked with Resident #11 stated that	F 329	The QA Nurse will audit all written medication orders on a weekly basis to ensure the potential does not exist and will request further orders from the physician/PA as necessary. Continued concerns will be reported to the QA&A Committee for further review.	10/20/11

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F 329	Continued From page 19 pharmacy (that inputs information on the facility electronic MAR) will sometimes include an alert to the nurses to not exceed 4000 milligrams of acetaminophen/day. Review of the electronic MAR for Resident #11 noted these alerts were not included with any of the orders and the three orders in place on 8/12/11 (Tylenol 650 every four hours PRN; Vicodin 5/500, two tablets three times a day and Vicodin 5/500 one every four hours PRN) were included on pages three (Vicodin 5/500, two tablets three times a day) and seven (Tylenol 650 every 4 hours PRN; Vicodin 5/500 every four hours PRN) of the resident's eleven page MAR. On 9/22/11 at 2:05 PM the physician assistant (PA) for Resident #11 stated their practice was to limit use of acetaminophen to 4000 milligrams/day. The PA stated the expectation was for nurses to monitor usage of acetaminophen, especially if there were PRN orders to ensure usage did not exceed the 4000 milligrams/day. On 9/22/11 at 2:45 PM the facility consultant pharmacist reported the maximum dosage of acetaminophen/day would be 4000 milligrams. The consultant pharmacist stated the pharmacy try to put alerts on orders but that it was not consistently done for all residents. The consultant pharmacist stated nursing staff is expected to know not to give greater than 4000 milligrams of acetaminophen a day. On 9/22/11 at 3:45 PM the Director of Nursing (DON) stated her expectation was for nurses to review all PRN and routine orders to ensure	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
	345264	A. BUILDING _____ B. WING _____	C 09/22/2011

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F 329	Continued From page 20 residents do not receive more than 4000 milligrams of acetaminophen in a 24 hour period.	F 329	No residents were harmed or noted to have any adverse effects to any of the findings.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to: ensure ice scoop holders in two (2) of two (2) pantries were cleaned; prevent thawed milkshakes from being stored in refrigeration beyond their manufacturer's recommendation of fourteen (14) days; ensure outdated items were removed from pantry refrigeration; ensure food was stored consistent with manufacturer recommendations; and ensure clean dishware was stored to prevent contamination. The findings are: 1. During the initial tour of the facility on 09/20/11 at 11:50 AM an ice scoop was observed stored in a clear ice scoop holder in the pantry on the 500 hall. Approximately a cup of water was pooled in the bottom of the ice scoop holder and the scoop portion was positioned in the water/coming in contact with the bottom of the container. When	F 371	The ice scoops/ice scoop holders on 400 and 500 units were cleaned and sanitized immediately upon discovery. The box of thawed milkshakes was removed from the refrigerator and discarded. All outdated items noted were immediately discarded, including the soup stored on top of the refrigerator. The bottle of lemon juice was immediately discarded. The clean racks and cups were immediately re-washed. All ice scoops and ice scoop holders were audited immediately with no other concerns noted for cleanliness. The refrigerator was checked by the FSD to ensure all items were properly labeled and dated. All nourishment rooms and pantries were audited and no other expired or unrefrigerated items were discovered.	9/20/11 9/21/11 9/20/11

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F 371	Continued From page 21 the ice scoop holder was removed from the wall and held to the light a gelatinous matter was noted on approximately 1/4 of the bottom of the container. This matter was felt and had a slimy texture. At the time of the observation the charge nurse for the 500 hall was asked about the cleaning schedule for the ice scoop holder. The charge nurse referred to a cleaning schedule posted on the wall which indicated the cleaning schedule for the pantry was "ice machine, refrigerator and microwave." The charge nurse observed the slimy matter and noted how easily it was removed with the touch of a finger. On 09/20/11 at approximately 11:55 PM a clear ice scoop was observed stored in a clear ice scoop holder in the pantry on the 400 hall. The scoop portion was stored inside and came in contact with the bottom of the holder. An area on the interior bottom of the holder measuring approximately 1" X 1/2" had a gelatinous, blackened appearance and felt slimy to touch. The QA (Quality Assurance) nurse was present at the time of the observation and was unaware who was responsible for cleaning the ice scoop/holder. On 09/20/11 at approximately 12:00 PM the Housekeeping Supervisor reported the dietary department was responsible for cleaning the ice scoop/holder. On 09/20/11 at 12:15 PM the Assistant Food Service Director stated they cleaned ice scoops/holders but relied on housekeeping to bring them to the kitchen for cleaning. 2. During the initial tour of the facility kitchen on 09/20/11 at 11:15 AM a thawed box of vanilla	F 371	The kitchen area was audited by the FSD and no other items on shelving were found to require refrigeration after opening. No other clean items were placed on the soiled side of the dish machine. Dietary staff will remove all ice scoops and holders daily from all units for sanitization. This will be documented on a form in each nourishment room by the assigned staff member. Milkshakes will not be moved from the freezer to the refrigerator to thaw but will be removed as needed for each meal and thawed just prior to serving. Dietary staff will be responsible for the removal of any expired item(s) from nourishment rooms/pantries twice daily as assigned by the FSD. This will be documented on a form located on each refrigerator. Ward Clerks on each unit will monitor each unit pantry routinely for compliance	9/21/11 10/20/11

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F 371	Continued From page 22 milkshakes was observed stored in the walk in refrigerator. This box contained 50 individual milkshakes and the manufacturer label on each individual carton indicated the milkshakes were good for fourteen (14) days after thawed. There was nothing to indicate when the milkshakes were thawed and the Food Service Director (FSD) and Assistant Food Service Director stated they were not sure when the box had been taken out of the freezer and placed in refrigeration. The FSD stated their practice was to pull one box out of the freezer at a time. The FSD stated there was only one resident receiving milkshakes and they were sent three times a day. The FSD stated there was not a system in place to ensure milkshakes were used within fourteen (14) days after thawed. 3. During the initial tour of the facility on 09/20/11 from 11:40 AM-12:20 AM outdated items were found in three of three nourishment pantries. These included the following: 500 hall-one, four ounce container of yogurt with a 9/12/11 expiration date. 100 hall-one, eight ounce container of honey thick milk with a 9/6/11 expiration date and a bowl of vegetable soup was stored on top of the refrigerator. 400 hall-one, six ounce container of yogurt with a 8/12/11 expiration date. On 09/20/11 at 12:20 PM the Assistant Food Service Director stated soup should not have been left unrefrigerated in the pantry and dietary staff was responsible for removing outdated items when stocking the pantry refrigerators. 4. On 09/21/11 at 10:55 AM a one gallon	F 371	and will report any continued concerns for expired foods and/or improperly stored food to the Administrator. All items used in the kitchen requiring refrigeration must be refrigerated properly. All clean items (dishes, racks, etc.) must be placed only on the clean side of the dish machine. Dietary staff was in-serviced on all policy and procedure changes and expectations within the department by the FSD on 10/20/11. QA monitoring tools will be utilized by the FSD to ensure ongoing compliance in each area noted. All ice scoop/holders, kitchen coolers, nourishment rooms/pantries, kitchen storage areas, and the dishwashing process will be audited randomly (3) times per week for the 1st month and then randomly each week for (2) months. Compliance will be reported to the QA&a Committee monthly by the FSD for (3) months or until resolved.	10/20/11

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
	345264	A. BUILDING _____ B. WING _____	C 09/22/2011

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F 371	Continued From page 23 container of lemon juice was observed on shelving in the kitchen. The lemon juice had been opened and had a handwritten date of 11/10 written on the outside of the container. The manufacturer label indicated, "refrigerate after opening". The Food Service Director (FSD) stated items should be refrigerated if indicated on the manufacturer label. The FSD could not explain why the lemon juice was stored unrefrigerated. 5. On 09/21/11 at 11:00 AM thirteen (13) clean racks and eleven (11) clean cups were stored directly on the dirty side of the dish machine table. This table had water and food debris pooled in the area where the racks/cups were stored. The Food Service Director was present at the time of the observation and reported there was a designated area for clean cups/racks to be stored. The dietary aide that stored the clean racks/cups on the dirty side of the dish machine reported she had temporarily placed them there prior to taking them to the designated area for clean dish storage.	F 371	Continued compliance will be monitored through random checks through the QA&A program.	
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;	F 441		

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F 441	Continued From page 24 (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. (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 medical record review, the facility failed to ensure staff used clean gloves during incontinence care for one (1) of eight (8) residents (Resident #5). The findings are: 1. Resident #5 was admitted to the facility with diagnoses of Alzheimer's Disease, stage three pressure ulcer, and perforated intestine, among	F 441	NA#5 was counseled and re-educated on proper use of gloves and Infection control guidelines.	9/29/11

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F 441	Continued From page 25 others. The latest Minimum Data Set (MDS) dated 09/16/11 revealed the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. The MDS further revealed the resident required extensive to total assistance with most activities of daily living, including extensive assistance with hygiene and bathing. On 09/21/11 at 10:46 AM Nursing Assistants (NA) #4 and #5 were observed performing routine catheter care and incontinence care for Resident #5. The NAs performed catheter care and then performed incontinence care for stool, cleaning front to back. During the incontinence care, NA #5 changed her gloves. She put a clean glove on her left hand, but as she attempted to put a clean glove on her right hand, she dropped the glove on the floor. She picked it up and again attempted to put it on her right hand, but she dropped it a second time. NA #5 picked up the glove a second time from the floor and put it on her right hand. Wearing these gloves, NA #5 then applied protective skin cream to the resident's backside, applying it with her right hand. On 09/21/11 at 11:08 AM, NA #5 was interviewed. She stated she should not have picked up the glove she dropped on the floor but instead she should have applied a clean glove. NA #5 gave no reason why she used the glove off the floor. On 09/21/11 at 11:18 AM, Licensed Nurse (LN) #3 was interviewed. She stated she expected NAs to obtain a clean glove if one was dropped on the floor.	F 441	All residents had the potential for being affected at any time—nursing staff will be in-serviced on proper infection control guidelines, including the proper use of clean gloves by the SDC on 10/20/11. Infection control procedures, including the use of clean gloves for all procedures, will be taught to all staff upon initial orientation and at least annually with employee performance appraisals. The QA Nurse will conduct a monthly infection control rounds on all shifts randomly to review proper infection control procedures with nursing staff. Any concerns from these rounds will be reported to the QA&a Committee on a monthly basis for recommendations as needed.	10/20/11 10/20/11

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F 441	Continued From page 26 On 09/21/11 at 11:25 AM, the Director of Nursing was interviewed. She stated it was part of infection control practice to use only clean gloves for procedures. She stated she expected all staff to use clean gloves and never pick up dropped gloves to use.	F 441	The QA Nurse will conduct monthly glove use audits randomly on all shifts for (3) months or until resolved and compliance will be reported to the QA&a Committee. Continued compliance will be monitored through random checks through the QA&A program.	10/20/11