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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____ DEC 14 2011	C 11/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVE NE CONCORD, NC 28025

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID # 5C3011 .	F 000	"Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction".	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to inform residents (who attended resident council meetings) of the purpose of the survey results book and to make them aware of the survey results book ' s location. The findings include: During the survey, the survey results book was observed on 10/18/2011 at 7:30am; 10/19/2011 at 7:45am; 10/20/2011 at 7:45am and on 10/21/2011 at 8:00am on the counter at the reception desk in the main lobby. The binder indicated that it contained survey results. On 10/20/11, the minutes from the Resident Council Minutes were reviewed for the months June, July, August, September and October, 2011. The minutes did not reflect that residents in	F 167	F 167 1. Corrective action was accomplished for resident #111 by informing resident of location and purpose of the facility survey results book on 10-24-11. 2. All residents who attend resident council meetings have the potential to be affected by alleged deficient practice therefore the location and purpose of the survey book was discussed at the resident council meeting on 10-26-11. 3. Measures/systems in place to ensure continued compliance are: Resident council meeting minutes will include the following information monthly: location and purpose of survey book.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Lewis — TITLE: Administrator — (X6) DATE: 12/12/11

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.

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F 167	Continued From page 1 attendance were informed of the location of the survey results book. On 10/21/2011 at 2:25pm, Resident #111, an officer with the Resident Council was interviewed. He stated that he attended the monthly council meetings and since his admission last December, no one has ever explained in their meetings, the purpose of a survey results book. He stated that he never heard of the survey book and did not know where it was located. On 10/21/2011 at 5:20pm, the Social Worker was interviewed. She stated that she facilitated the resident council meetings. Part of their agenda included reviewing resident rights and how to contact state agencies and advocacy groups. She stated that it was not her practice to discuss the survey book or where it was located because she did not know that it was required. She shared that she was a fairly new employee and at the time of her training, she did not receive instruction to inform residents about the survey results book. She stated that now that she knew that it was an expectation, she would share that information at future meetings with the residents.	F 167	During the monthly resident council meeting the location and purpose of the survey book will be discussed every month by the facility Social Worker or in her absence by the facility Activities Director. The resident council president will verify the content of the meeting by his/her signature. 4. The facility Social Worker and in her absence the Activities Director will be responsible for writing the minutes, submitting them to the resident council president for signature and then to Administrator for review. The facility Administrator will monitor the minutes of the resident council meeting for compliance and initial the minutes every month for three months for compliance and then quarterly and present to the QA & A committee. Compliance date: 12/2/2011 and ongoing.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		

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F 242	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to involve an alert and oriented resident in making choices regarding how to address health concerns for 1 of 7 sampled residents (Resident #81). Resident #81 was admitted on 2/17/11 and readmitted on 8/26/11 with diagnoses including: cerebral vascular accident, seizure disorder, depression and diabetes mellitus. The resident also developed an Extended Spectrum Beta Lactamases (ESBL) Urinary Tract Infection (UTI) and was on contact precautions. Review of the Nurses Notes dated 7/12/11 at 7:50 AM revealed a note that read " This nurse spoke (with) res (resident) about why pt (patient) is on isolation. Res is on isolation d/t (due to) infection in urine. Res has been noted on several occasions to be playing in her vaginal area and not washing hands. D/t this res must stay in room until cleared from isolation. " There was no documentation indicating resident education regarding hand washing. There was no documentation indicating the resident had been involved in exploring alternatives to room restriction while on contact precautions. There was no documentation specifying the location (privately in her room or in a public area) of where the resident had been observed " playing in her vaginal area. " There was no documentation that any inappropriate sexual behavior was discussed with the resident in an attempt to resolve the issue. The nurse who wrote the above note was	F 242	F242 1. Corrective action was accomplished for resident #81 with receipt of a negative urine culture and the physician discontinuing isolation. The resident was informed of both results on 10-21-11 and is currently participating in activities/events outside of her room. 2.Other residents who are placed on isolation and who are or have the potential to be placed on isolation and be restricted to their rooms are being identified by the facility interdisciplinary team (IDT) comprised of the Director of Nursing (DON), Staff Development Coordinator (SDC), Social Worker (SW), Activities Director (AD), Dietary Manager (DM) during the daily (Monday thru Friday) Clinical Meeting by reviewing and discussing the 24 hour nursing report and new physician orders. Residents/Legal representatives with health concerns, including placement on isolation procedures will be invited to their scheduled care	

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F 242	Continued From page 3 unavailable for interview. Review of the medical record revealed no other documentation of physical behaviors directed towards self or others and no documentation of discussions with the resident regarding the topic. The most recent comprehensive Minimum Data Set (MDS) assessment, a significant change assessment, dated 7/19/11 revealed the resident was cognitively intact, had no symptoms of an alteration in mood and was incontinent of bowel and bladder. No behavior symptoms were checked including physical behavior symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and physical behavior symptoms not directed towards others (e.g., hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public). Review of the medical record revealed Resident #81 was discharged to hospital on 7/20/11 and readmitted to the facility on contact precautions on 7/25/11 Review of the care plan dated 7/25/11 revealed the following problem statement " (Resident name) has a life long history of depression. " The goals were " (Resident name) will participate in at least one activity per week " and (Resident name) will not experience any increase in depression " . Approaches for achieving these goals included: 1) refer to psychological counseling, 2) allow to verbalize feelings, 3) support and facilitate privacy for (name of resident) and visitors, 4) allow choices regarding schedule, 5) observe for changes in mood, 6)	F 242	plan meeting where they can discuss their concerns and options regarding isolation procedures. Documentation validating their invitation and attendance or desire not to attend will be recorded in the medical record by the SDC or in her absence the DON or ADON. 3. Measures/systems to ensure continued compliance are: Any resident that is determined to require room restriction will be educated by the DON, ADON or SDC on cause of and need for isolation and any room restriction. Prior to restricting resident to room, all causative factors will be discussed with the resident by the physician, DON, ADON and/or SDC. If room restriction is necessary this will be communicated also to the resident by the DON, ADON or SDC and reviewed weekly during the daily clinical meeting and the care plan updated accordingly by the SDC, DON or ADON. The resident will be informed of weekly reviews and any changes that may have been determined.	

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F 242	Continued From page 4 select seating at activities and in dining room, 7) evaluate effectiveness of antidepressants, 8) monitor for suicidal ideation, provide opportunities for increased socialization, 9) provide opportunities to correspond with others. Review of the Care Plan Progress notes dated 8/3/11 read, in part, " Significant (change) CP (care plan) meeting held (with) disciplines. Res (Resident) own RP (Responsible Person) and did not attend. " " (No) documented behaviors. " " res is on contact isolation for ESBL urine, res has been treated (with) IV (intravenous) abt ' s (antibiotics) via PICC line. Res is now on oral ABT ' s. " Review of the physician ' s progress note dated 8/9/11 read, in part, " The patient has been crying uncontrollably for the past day and she stated that she does not know what is happening with her. So physician visit was requested. " Under assessment and plan it read, in part, " Delirium with acute anxiety: I had discussed with the patient about her condition and tried to explain that she is improving but she could not be consulted. " " She is presently in an isolation room and remains behind closed doors with little interaction with other residents that makes things worse for her. We will move her to a room closer to the nursing station with possible with a good window view, it might help to cheer her up and improve her delirium. " Review of the physician ' s notes revealed no discussion with the resident regarding alternatives to room restriction while on contact precautions. There was no indication that the resident was aware restrictions while on contact precautions could be lifted if she would adhere to certain requirements, such as hand	F 242	The facility SDC will be responsible for monitoring all residents requiring isolation restrictions, care plan updating and resident education weekly as long as resident is on isolation. This information will be recorded in the resident's medical record by the SDC. An in-service was conducted on 10-24-11 and 10-25-11 by the Director of Nurses for the licensed nurses representing all three shifts regarding the rights of residents to make choices when in isolation and when expressing other health concerns. The facility monthly care plan schedule that is maintained by the SDC or SW will include the following information: Time and date of scheduled meeting, Resident name, Type of assessment, Resident /legal representative Invitation Date, Attendance or desire not to attend of resident and/or legal representative. 4. The facility social worker or SDC will monitor the care plan schedule for attendance and participation monthly and	

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F 242	Continued From page 5 washing and not touching her vaginal area while out of her room. Review of the Psychiatric Services consultant note dated 8/18/11 read, in part, " she has been confined to her room however because of some infectious process. " " When I talked with the patient she reports it has been very difficult to deal with but that she is handling it as best as well as can be expected. There was no assessment or recommendation in the notes regarding physical behaviors including sexual or attention seeking behaviors. Review of the medical record revealed Resident #81 was discharged to hospital on 8/21/11 and readmitted to the facility on contact precautions on 8/26/11. Review of the medical record revealed Resident #81 was discharged to hospital on 9/19/11 and readmitted to the facility on contact precautions on 9/26/11. The Quarterly MDS Assessment dated 9/30/11 revealed the resident had no short or long term memory problems, was moderately impaired in decision making, had no symptoms of alteration in mood and had an indwelling catheter. No behavior symptoms were checked at E0200 including physical behavior symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and physical behavior symptoms not directed towards others (e.g., hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public).	F 242	present this information to the QA & A committee monthly for three months and then quarterly. Compliance date: 12/2/2011 and ongoing.	

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F 242	Continued From page 6 Observation of the resident on 10/19/11 at 10:43 AM revealed she was in a room without a room mate and on contact isolation precautions. Interview with Resident #81 on 10/19/11 at 10:43 AM revealed that she used to participate in all the facility ' s activities before she need to go on isolation precautions. She stated that she had been in her room on isolation for a month and was becoming depressed. She also stated that she had a recent urine test and no one would tell her the results when she asked. She really wanted to know so she could find out when she would be able to leave her room, eat in the dining room and participate in activities again. A hand written update on 10/19/11 read " (no) increase in depression since last review. Enc (encourage) to participate in activities weekly. " Review of the Care Plan Progress Notes dated 10/19/11 read, in part, " CP meeting held with disciplines. Res own RP and not in attendance. Res health and weight status discussed. " " Res is on ABT for UTI/ESBL in urine. Continues on contact isolation. " On 10/20/11 at 3:40 the Activities Director (AD) was interviewed and stated that Resident #81 used to participate in all the activities and would be the first resident in the Activities room when staff arrived in the morning. The AD said that the Activities Assistant was visiting with the resident for 1:1 daily (Monday to Friday) for 15 minutes. She added that being in her room was getting the resident down and that hopefully she would be able to come out of her room soon.	F 242		

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F 242	Continued From page 7 Interview with the Director of Nursing (DON) and the Administrator on 10/21/11 at 8:50 revealed the resident was on contact isolation due to an Extended Spectrun Beta Lactamases (ESBL) urinary tract infection (UTI). The DON stated that while on contact isolation the resident needed to stay in her room because Resident #81 had been seen touching her vaginal area while in public areas of the facility and this posed a risk for cross contamination. The DON said that she had not seen the resident do this but another nurse (who was not available for interview) had seen it and wrote the Nursing Note on 7/12/11 (see above). The DON added that Resident #81 had also touched staff inappropriately. The DON indicated that Resident #81 was receiving 1:1 activities in her room and Physical Therapy in her room as there was a concern that even with staff present it was unknown if she would touch her vaginal area and potentially put others at risk of exposure. The DON indicated that the self touching in public was clearly for pleasure and not due to symptoms of a UTI. She had no information regarding who spoke with the resident about this issue after 7/12/11. When questioned as to how the resident ' s public sexual behaviors would be addressed when there was no further need for isolation she stated that she felt these behaviors had been associated with attention seeking but that they had diminished and the resident could be redirected now that she had settled into the facility. She also stated that she was aware the resident was " going a little stir crazy " in her room and they would revisit the plan of care to see what alternatives could be trialed. On 10/21/11 at 9:15 AM the Social Worker (SW) was interviewed. She stated that Resident #81	F 242		

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was her own RP and was invited to the Care Plan meeting on 10/19/11 but did not want to attend. She stated that the invitation was given to the resident in letter format on 10/12/11 and provided a copy of the letter. The SW was unsure who may have reminded the resident of the meeting and encouraged her to attend. She also did not know if the resident was informed that she could come to the meeting while she was on contact precautions or that the meeting could be held in her room. The SW thought the nursing staff would have invited the resident on the day of the meeting but she was unsure who. She added that she need to be clear in her documentation of the resident not wanting to attend versus the resident just not attending.

Review of the Care Plan meeting invitation (undated) provided to the resident read, in part, " Re: (name of Resident) You are invited to attend a Care Plan Review, which has been scheduled for your loved one on Wednesday October 26th, 2011 (at) 11:30am-11:45am " . " Please RSVP (respond) to (name of Social Worker), BSW at (phone number), between the hours of 8am and 4:30pm Monday through Friday " . The SW was not interviewed regarding the contents of the letter or regarding the date of the meeting being 10/26/11, per the letter, but being held on 10/19/11 per the Care Plan Progress Notes.

On 10/21/11 at 11 AM interview with the resident ' s physician revealed the resident was on contact precautions due to recurrent ESBL urinary tract infections (UTI ' s) that were very resistant to treatment despite a series of intravenous antibiotics and several hospitalizations. He stated the resident had neurogenic bladder and urinary

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retention which made her prone to these infections and that she tended to get septic with UTI ' s, so was being followed by urology. The physician said one further negative urine culture was required to ensure the ESBL infection was cleared and until then the resident would need to remain in her room on contact precautions due to her history of touching her vaginal area in public. He stated that the resident had been seen doing this in the hall outside the nursing station and that she also liked to reach out and touch or grab people as they walk by.

Interview with Nurse #2 at 12:01 PM on 10/21/11 revealed Resident #81 had inappropriately touched him twice; once she rubbed his groin and once she rubbed his buttocks. He stated that the last incident was 6 weeks ago and that he had documented it in the nursing notes. Nurse #1 said that he had not seen the resident with her hand down her pants in a public area but he had seen her do this in her room.

Interview with Nursing Assistant # 2 on 10/21/11 at 1:46 PM revealed that she had not seen the resident with her hand down her pants in a public area but she had heard the resident had touched staff inappropriately, although she was unaware of the details. She stated that when the resident was up she was in her wheelchair and was able to mobilize in her room freely. She also stated that the Resident #81 was aware she was on isolation and that she needed to stay in her room, and that she had never tried to leave her room on her own.

On 10/21/11 at 2:45 PM Resident #81 was interviewed and stated that she was taken out of

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F 242	Continued From page 10 her room for showers twice a week and to get her hair done weekly. She said that (name of Activity Assistant) visited with her daily and she enjoyed these visits but they were to short. Resident #81 said she would like more time with (name of Activity Assistant) until being able to be off isolation. She also stated that she had another urine test and wanted to know the results and when isolation would be discontinued but no one would tell her. She added that staff got her up in her wheelchair when she wanted to be up and that she could move around her room in her wheelchair freely. Resident #81 added that because she had to stay in her room most of the time she thought she might as well stay in bed more and watch TV so she wasn ' t getting up as much. Interview with the DON on 10/21/11 at 3:30 PM revealed the resident had a second negative urine culture and she would be calling the doctor for an order to discontinue contact precautions and would ensure the resident was informed. On 10/21/11 at 4:30 PM Resident#81 ' s room was observed. The sign for contact precautions had been removed and the resident and her wheelchair were not in the room.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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F 279	Continued From page 11 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to care plan behaviors for one (1) of four (4) residents (Resident #81), ostomy care for Resident # 140 and a catheter for one (1) of three (3) residents (Resident #17). Findings included: 1) Resident #81 was admitted on 2/17/11 and last readmitted on 8/26/11 with diagnoses including: cerebral vascular accident, seizure disorder, depression and diabetes mellitus. Review of the Nurses Notes dated 7/12/11 at 7:50 AM revealed a note that read " This nurse spoke (with) res (resident) about why pt (patient) is on isolation. Res is on isolation d/t (due to) infection in urine. Res has been noted on several occasions to be playing in her vaginal area and not washing hands. D/t this res must stay in room until cleared from isolation. "	F 279	F279 1. Resident # 81, #17 and resident #140 have had their care plans updated. Resident # 81 had his/her care plan updated on 10/21/2011 to reflect her/his behaviors. Resident # 140 had the care updated on 10/21/2011 to reflect the presence of an ostomy device. Resident #17 had his/her care plan updated to reflect presence of a catheter on 10/21/2011. 2. All residents have the potential to be affected by the deficient practice. Residents that have the potential to be affected by the deficient practice will have charts and care plans audited, per SDC and DON for appropriate and updated care plans. Audit to be completed 12/15/2011. 3 The facility will institute the following measures to ensure that the deficient practice will not occur: DON, ADON and/or SDC will review of the Nursing 24 hour report at the daily clinical meeting to review physician orders, and need for	

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F 279	Continued From page 12 The most recent comprehensive Minimum Data Set (MDS) assessment, a significant change assessment dated 7/19/11, revealed the resident was cognitively intact, had no symptoms of an alteration in mood and no behavior symptoms were checked at E0200 (physical behavior symptoms directed towards others and physical behavior symptoms not directed towards others). Review of the medical record revealed no other documentation of physical behaviors directed towards self or others. Review of the care plan dated 7/25/11 and updated on 10/19/11 revealed the following problem statement " (Resident name) has a life long history of depression. " The goals were " (Resident name) will participate in at least one activity per week " and (Resident name) will not experience any increase in depression " . A hand written update on 10/19/11 read " (no) increase in depression since last review. Enc (encourage) to participate in activities weekly. " Approaches for achieving there goals included: 1) refer to psychological counseling, 2) allow to verbalize feelings, 3) support and facilitate privacy for (name of resident) and visitors, 4) allow choices regarding schedule, 5) observe for changes in mood, 6) select seating at activities and in dinning room, 7) evaluate effectiveness of antidepressants, 8) monitor for suicidal ideation, provide opportunities for increased socialization, 9) provide opportunities to correspond with others. Physical behavior symptoms directed towards self or others was not addressed in the care plan. Interview with the Director of Nursing (DON) and	F 279	updating and/or initiating care plans. Upon findings, appropriate care plans will be updated and/or initiated. MDS Coordinator will be responsible for initiating care plans identified through the comprehensive MDS assessment. Audits of the weekly scheduled care plans will be done by DON or SDC to ensure comprehensive care plans are in place per triggered areas via the MDS assessment. After completion of initial MDS assessment, care plans will be audited per IDT for appropriate care plans and correcting of any discrepancies identified. 4. The results of the audits will be reviewed by the DON at the monthly QA & A monthly times 3 months and then quarterly. Compliance Date: 12-2-2011 and ongoing.	

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the Administrator on 10/21/11 at 8:50 revealed the resident was on contact isolation due to an Extended Spectrun Beta Lactamases (ESBL) urinary tract infection (UTI). The DON stated that while on contact isolation the resident needed to stay in her room because Resident #81 had been seen touching her vaginal area while in public areas of the facility and this posed a risk for cross contamination. The DON said that she had not seen the resident do this but another nurse (who was unavailable for interview) had seen it and wrote the Nursing Note on 7/12/11 (see above). The DON added that Resident #81 had also touched staff inappropriately. On reviewing the care plan the DON acknowledged there was no care plan to address these behaviors.

On 10/21/2011 at 9:40 AM., the MDS Coordinator stated the care plans were updated by the Staff Development Coordinator.

The Staff Development Coordinator was unavailable for interview.

Interview with Nurse #2 at 12:01 PM on 10/21/11 revealed Resident #81 had inappropriately touched him twice; once she rubbed his groin and once she rubbed his buttox. He stated that the last incident was 6 weeks ago and that he had documented it in the nursing notes. Nurse #2 said that he had not seen the resident with her hand down her pants in a public area but he had seen her do this in her room.

On 10/21/11 at 3:14 pm., the Director of Nursing stated clinical meetings were held daily Monday through Friday. At that time, discussion was held regarding changes in the resident, new orders,

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etc. The changes on the care plans would be made at that time. The nursing staff that worked on the unit could also update/ initiate the care plan. The MDS Coordinator would update the care plan based on the MDS information.

2) Resident #140 was admitted on 6/21/11 and readmitted 9/16/11 with diagnoses including diabetes mellitus, stage 4 sacral pressure ulcer with methicillin-resistant Staphylococcus aureus (MRSA) infection, and recent amputation right leg. The resident also had a colostomy.

Review of the Admission Minimum Data Set (MDS) dated 9/23/11 revealed the resident was checked for an ostomy (includes colostomy) under Bladder and Bowel Function. Review of the Care Area Assessment for this MDS revealed the colostomy was not addressed in any of the triggered care areas.

Review of the care plan for Resident #140, dated 9/26/11, revealed there was no care plan for colostomy care. The colostomy was also not addressed in any other areas of the care plan.

Interview with the Director of Nursing (DON) and the Administrator on 10/21/11 at 8:50 revealed Resident #140 has a colostomy and therefore should have a care plan for colostomy care. On review of the care plan the DON noted that colostomy care was not addressed in the resident ' s care plan.

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F 279	Continued From page 15 3) Resident #17 was admitted to the facility 1/3/2009 and last readmitted to the facility 9/23/11. Current diagnoses included: Recent urinary tract infection with sepsis syndrome, acute renal failure due to acute tubular necrosis secondary to sepsis (resolved in hospital) and urinary retention (9/28/11). During the resident interview conducted on 10/18/2011 at 1:36 PM., resident #17 was observed with a urinary drainage bag at bedside. A Physician order dated 9/29/11 indicated "Insert #16/ 5 fr. (French) F/C (foley catheter). Attach drainage bag--for urinary retention." Annual Minimum Data Set (MDS) assessment dated 1/25/11 indicated Resident #17 was impaired with cognition. No mood or behavior problems noted. Resident #17 required total assistance with toileting. On this assessment, resident was frequently incontinent of urine and always incontinent of bowel. Care area assessment summary for urinary incontinence dated 1/25/11 stated resident had a long history of incontinence and was not a good candidate for programs due to physical limitations. Quarterly MDS assessment dated 9/29/11 stated resident had short term and long term memory impairment and was severely impaired in decision-making. Resident required total assistance with toileting. This assessment indicated resident was incontinent of bladder and bowel. Indwelling catheter was checked.	F 279		

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F 279	Continued From page 16 Care plan dated 1/25/11 and last reviewed 10/12/11 indicated resident was at risk for loss of skin integrity related to reduced mobility and incontinence. Approaches included: weekly skin checks, assist to turn and position in bed, keep clean and dry on care rounds and as needed and use of a pressure reducing mattress. Use of urinary catheter was not care planned. Nursing notes were reviewed and indicated a urinary catheter was inserted on 09/29/2011. On 10/21/2011 at 9:40 AM., the MDS Coordinator stated she had not implemented a care plan for urinary catheter for Resident #17. She indicated she would include it in her next quarterly assessment. She stated the care plans were updated by the Staff Development Coordinator. The Staff Development Coordinator was unavailable for interview. On 10/21/11 at 3:14 pm., the Director of Nursing stated clinical meetings were held daily Monday through Friday. At that time, discussion was held regarding changes in the resident, new orders, etc. The Director of Nursing indicated she received a copy of all the orders and gave them to the Staff Development Coordinator for review. The changes on the care plans would be made at that time based on the orders. The nursing staff that worked on the unit could also update/ initiate the care plan. The MDS Coordinator would update the care plan based on the MDS information. She stated she expected the use of the urinary catheter to be noted on Resident's active plan of care within twenty four hours (by the next day).	F 279		

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F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews, the facility failed to update the care plan for one (1) of four (4) residents surveyed for ADL (activity of daily living) care (Resident #107) and failed to allow two (2) of three (3) alert and oriented residents to participate in care planning (Resident # 75, Resident #141). Findings included: 1. Resident #107 was admitted to the facility on 2/23/10 and readmitted on 12/30/10. Cumulative diagnoses included status post cerebrovascular	F 280	F280 1. Corrective action has been accomplished for resident #107 by updating the ADL care plan; Resident #75 by reviewing the care plan with the resident on 11-28-11; and Resident #141 was discharged from the facility on 11-9-11. 2. All residents have the potential to be affected by the deficient practice. Residents that have the potential to be affected by the deficient practice will have charts and care plans audited, per SDC and DON for appropriate and updated care plans. Audit will be completed 12/15/2011. 3. Measures/systems to ensure continued compliance are: The facility will institute the following measures to ensure that the deficient practice will not occur: DON, ADON and or SDC will review the Nursing 24 hour report at the daily clinical meeting to review physician orders, and need for updating	

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F 280	Continued From page 18 accident with right sided paralysis, cognitive impairment and memory loss. Resident #107 ' s most recent Minimum Data Set (MDS), a quarterly dated 10/2/11, indicated that she was totally dependent for bathing, hygiene and transfers. Resident #107 ' s care plan dated 1/11/11 included a problem of self care deficit. On 4/27/11 the problem was updated to read, " Res (resident) requires total care for all ADLS (activities of daily living). Cont (continue) POC (plan of care) x 90 d (days). The care plan goal read, " Will meet therapy goals x 90 days " through 10/27/11. Approaches included (1) assist with ADLs as needed, (2) therapy as ordered, (3) sliding board transfers as able, (4) encourage resident to do as much as possible for herself, and (5) keep frequently used items in same location. Review of Physical Therapy notes dated 2/4/11 revealed that Resident #107 was discharged from therapy due to poor participation. Review of physician orders revealed no current order for physical therapy. During an interview on 10/19/11 at 3:58 PM, Nurse #1 stated that Resident #107 was totally dependent on staff for her care. On 10/20/11 at 11:30 AM, Resident #107 was observed receiving care from nursing assistant (NA) #1. The resident reached for the side rail with her left hand when she was turned onto her right side. The resident was provided incontinent	F 280	and/or initiating care plans. Upon findings, appropriate care plans will be updated and/or initiated. The MDS Coordinator will be responsible for initiating care plans identified through the comprehensive MDS assessment. Documentation validating the resident's invitation, attendance or desire not to attend will be made by the SDC, Social Worker or designated licensed nurse participating in the care plan meeting at time of the care plan meeting. In-service education for IDT team on the care planning process was conducted by the DON on 10-25-11. An audit of the accuracy of weekly scheduled care plans will be completed by DON or SDC to ensure comprehensive care plans are in place per triggered areas via the MDS assessment. After completion of initial MDS assessment, care plans will be audited per IDT for appropriate care plans and	

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F 280	Continued From page 19 care. During an interview on 10/20/11 at 11:35 AM, NA#1 indicated that beyond helping to turn, Resident #107 was unable to participate in her care. NA#1 stated that 2 staff got her up using a total lift. NA#1 said that the resident never used her call light. During an interview on 10/20/11 at 2:40 PM, the director of nursing (DON) indicated that Resident #107 was totally dependent on staff and had not received therapy for quite some time. The DON added that the plan of care should have been updated when the resident ' s problem changed to needing total assistance with care. 2) Resident #141 was admitted on 8/28/11 with diagnoses including congestive heart failure, diabetes mellitus, chronic kidney disease and hypertension. Review of the Admission Minimum Data Set (MDS) dated 9/4/11 revealed the resident was moderately cognitively impaired, had no hearing problems and spoke clearly. The MDS also indicated that Resident #141 was able to make herself understood and usually understands; in that she misses some part/intent of message but comprehends most conversation. The resident participated in the assessment and indicated she expected to remain in the facility. Review of the Social Service Notes dated 9/2/11 read in part " patient is alert and verbal. " Review of the Social Service Notes dated 9/21/11 read, in part, " Initial careplan reviewed today.	F 280	correcting of any discrepancies identified. 4. The DON will review findings of audits with the QA & A Committee monthly for three months and then quarterly. The facility social worker will monitor the care plan schedule for attendance and participation and present this information to the QA & A committee monthly for three months and then quarterly. Compliance Date: 12-2-11 and ongoing.	

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RP (Responsible Person) invited and did attend. Resident remains alert and verbal (with) periods of confusion. RP is undecided of resident ' s plans for d/c (discharge). "

Review of the Care Plan Progress Notes dates 9/21/11 read, in part, " initial CP (care plan) meeting held with disciplines. RP invited and in attendance. "

Interview with the resident on 10/19/11 at 11:02 AM revealed that she is not invited to care plan meetings.

On 10/20/11 at 4:35 PM, the Social Worker (SW) was interviewed and stated she wrote and sent the letters to invite the RP ' s to care plan meetings and if a resident was their own RP she gave them a letter to invite them. She stated that residents are asked if they want to attend but she had no documentation of this.

3) Resident #75 was admitted to the facility 7/26/2010. Current diagnoses included: post traumatic brain syndrome, depression and anxiety.

Annual Minimum Data Set (MDS) dated 4/27/11 indicated resident #75 was alert and oriented.

Quarterly MDS dated 7/22/11 indicated resident was alert and oriented.

Care plan meetings attendance sheet were reviewed. Signatures of attendance at May 11, 2011, August 10, 2011 and October 19, 2011 care plan meetings were the Activity Director, Dietary Manager, Social Worker and a

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F 280	Continued From page 21 representative from nursing. SW notes were reviewed and indicated that resident #75's responsible party (RP) was invited to care plan meetings and RP did attend meetings on 2/9/11, 5/11/11, 8/10/11 and 10/19/11. On 10/20/2011 at 4:30 PM., Resident #75 stated her mother attended any other meetings that related to her care. Resident #75 stated she did not know that care plan meetings were held and said she would like to be invited to the meetings and she would make up her own mind if she wanted to attend. On 10/20/11 at 4:35 pm., the Social Worker stated she wrote the letters and invited the RP to care plan meetings. If the resident was alert and oriented, they were given a letter also and asked if they wished to attend care plan meeting. When asked regarding Resident #75, the Social Worker stated the letter was always given to the RP. She stated Resident #75 was not invited to the last care plan meeting and she did not have any documentation that Resident #75 had been invited and/or refused to attend care plan meeting.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F314 1. Corrective action was accomplished for Resident #135 on 11-8-11. The facility DON and Wound Care Nurse (WCN) re-measured and accurately documented the size and staging of the wound on the resident's left lower leg ulcer.	

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F 314	Continued From page 22 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, physician interview and record review, the facility failed to accurately measure pressure ulcers for 1 of 7 residents (Resident #135). The findings included: Resident #135 was admitted to the facility on 4/29/11 and readmitted on 6/6/11. Diagnoses included recent enterococcal sepsis, encephalopathy related to alcoholism or Wilson's disease, pulmonary embolism, malnutrition on tube feeds, sacral and lower extremity decubiti, status post wound VAC (vacuum assisted closure) hypertension, chronic hypokalemia and hypomagnesemia, history of panic attacks, spinal cord disease, muscle disuse atrophy and recurrent urinary tract infection. The significant change Minimum Data Set (MDS) assessment dated 6/15/11 and quarterly MDS dated 9/9/11 indicated that Resident #135 had memory problems, severely impaired cognitive skills for daily decision making, was totally dependent on staff for activities of daily living including bed mobility, eating, received more that 51% of total calories through a feeding tube, and was at risk for pressure ulcers. The MDS of 6/15/11 revealed that the resident had a significant weight loss and one stage 2 and one stage 3 pressure ulcer. The MDS of 9/9/11 revealed two stage 2 pressure ulcers and one	F 314	2. Residents with wounds have the potential to be affected by alleged deficient practice; therefore current residents with wounds were reviewed, re-measured and accurately documented on 11-8-11 by the facility DON, WCN and Staff Development Coordinator (SDC). 3. Measures/systems in place to ensure continued compliance are: Weekly wound rounds will be made by the DON, ADON, SDC and/or WCN. Measurements will be completed and compared to previous measurements. The WCN will document what the rounding team determines to be accurate. All data will be immediately transcribed on the facility medical record form. The WCN will review results with the physician weekly until the wound heals or resident is discharged. The DON reviewed the methodology and practice of measuring wounds that is	

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F 314	Continued From page 23 stage 3. The care plan dated 9/14/11 listed a problem of pressure ulcers. Approaches included weekly skin checks, turn on rounds, and wound care as ordered. Review of the Wound/Skin Progress Notes dated 11/1/11 revealed that the stage 2 heal wound had closed. The gluteal wound remained open and the Wound/Skin Healing Record revealed weekly measurements. (The resident refused to have the gluteal wound observed on 11/7/11.) November 2011 Physician Orders included an order, beginning 8/6/11, to clean left lower leg with normal saline, apply Silvadene (a topical antibiotic) and cover daily until healed. Wound care notes dated 6/7/11 read, "Ulcer to left lower leg with intact eschar." The Wound/Skin Healing Record for the stage 3 left lower leg ulcer revealed the following: 6/13/11: 7.1 cm (centimeters) long x (by) 4.6 cm wide x 0.1 cm deep 6/20/11: 6.4 cm x 3.9 cm x 01. cm 6/27/11: 2.4 cm x 2.1 cm x 0.1 cm 7/3/11: 2.2 cm x 2.1 cm x 0.1 cm 7/11/11: 4.2 cm x 2.6 cm x 0.1 cm 7/18/11: 2.4 cm x 0.6 cm x 0.1 cm 7/20/11: 2.8 cm x 1.4 cm x 0.1 cm 7/27/11: 3.6 cm x 1.9 cm x 0.1 cm 8/3/11: 2.4 cm x 1.2 cm x 0.2 cm 8/8/11: 3.4 cm x 2.6 cm x 0.3 cm 8/17/11: 2.6 cm x 1.3 cm x 0.2 cm 8/24/11: 2.6 cm x 1.4 cm x 0.2 cm 8/31/11: 2.6 cm x 1.2 cm x 0.2 cm 9/7/11: 2.9 cm x 1.4 cm x 0.2 cm 9/14/11: 2.9 cm x 2.6 cm x 0.2 cm	F 314	documented in the Facility Wound Care Manual with the ADON, WCN and SDC. 4. The DON will review the wound documentation weekly and report these findings every month at the QA&A meeting. Compliance date: 12-2-11 and ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 11/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVE NE CONCORD, NC 28025

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F 314	Continued From page 24	F 314		

9/21/11: 3.1 cm x 2.8 cm x 0.2 cm
9/28/11: 3.1 cm x 2.9 cm x 0.2 cm
10/5/11: 3.0 cm x 2.9 cm x 0.2 cm
10/12/11: 3.0 cm x 2.9 cm x 0.2 cm
No further entries were on the Wound/Skin Healing Record. The Wound/Skin Care Progress Notes revealed the following:
10/20/11: 3.0 cm x 2.9 cm x 0.2 cm
10/25/11: 3.0 cm x 2.8 cm x 0.2 cm
11/1/11: 2.9 cm x 1.4 cm x 0.2 cm
The pressure Ulcer Tracking Log for the week of 10/31/11-11/6/11 revealed:
11/2/11: 3.0 cm x 2.8 cm x 0.2 cm

On 11/7/11 at 11:35 AM, the left calf wound was observed. Measurements taken by the Wound Care Nurse (WCN) were 11.4 cm x 2.1 cm x 0.8 cm. The distal half of the wound bed was granulated with the exception of the most distal aspect which revealed a 1 cm area of slough. The distal half was approximately 0.2 cm deep. The upper half of the wound gradually deepened to 0.8 cm as measured. A tunneling depth of 0.7 cm was measured at the most superior aspect of the wound edge.

During an interview on 11/7/11 at 11:50 AM, NA#3 indicated that she did the daily wound treatments for Resident #135 and on Wednesdays the WCN measured the wounds. NA#3, who was present during the observation at 11:35 AM, indicated that the resident's leg wound had always been about the size that was just observed.

During an interview on 11/7/at 4:09 PM, the WCN said that the slough and tunneling were new and she had reported this to the physician who said

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F 314	Continued From page 25 he would look at it on 11/8/11. She said that the size of the wound was about the same. The WCN added that she could not explain the discrepancy in the measurements from what was on the chart to what was measured on 11/7/11. During an interview on 11/7/11 at 4:45 PM, the physician stated that he generally looked at wounds if the staff had a concern, and had not looked at Resident #135's leg wound. The physician stated he reviewed the weekly Pressure Ulcer Tracking Log and expected the measurements to be accurate. During an interview on 11/7/11 at 5:50 PM, the Director of Nursing (DON) stated that she expected wound measurements to be accurate.	F 314		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334	F334 1. Residents #1, #2 and #12 received this year's flu vaccine in September 2011 without an annually signed informed consent form discussing the risks and benefits of the vaccine filed in their medical record. None of the above residents experienced any side-effects from the drug. 2. All residents have the potential to be affected by the alleged deficient practice therefore no resident will receive flu or pneumonia immunizations without prior	

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F 334	Continued From page 26 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal	F 334	authorization, consent on an annual basis, and discussion of risks and benefits. 3. Measures/systems in place to ensure continued compliance are: The facility Admission Coordinator will continue to ensure that new admissions and re-admissions and/or their legal representatives have received the consent form and information regarding risk/benefits of the influenza and pneumococcal on their day of admission/re-admission. The facility SDC and/ or DON is responsible for ensuring all other residents/ legal representatives receive the risk/benefit information and signed consent annually. All informed consent forms which include the risk/benefits education requirement will be reviewed by the DON or ADON with the SDC prior to the administration of any vaccine. No vaccine will be administered unless the consent has been signed indicating that the	

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F 334	Continued From page 27 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide education regarding the benefits and potential side effects of the influenza vaccine to the resident or legal representative each time the vaccine was offered to 3 of 5 sampled residents (Residents # 1, #2 and #12) as required. The findings include: On 10/20/11, a copy of the facility ' s undated policy on Immunization: Influenza vaccinations for residents, staff and volunteers were reviewed. It read, " Current and newly admitted residents will be offered the influenza vaccine from September of each year through the end of March the following year. Informed consent in the form of discussion regarding risks and benefits of vaccination will occur prior to vaccination. " 1. Resident #1 was re-admitted to the facility on 4/10/2009. A review of her chart indicated that an influenza vaccine was administered on 9/21/2011. The last education material on file, outlining the benefits and potential side effects of the influenza immunization was signed by her legal representative on 10/15/2004. On 10/21/2011 at 9:25am an interview was	F 334	risk/benefit education has been received. Annual consent forms/risk benefits education will either be sent to the legal representative by mail, delivered verbally in person or in a group meeting annually. Residents will receive this information verbally. The Center for Disease Control (CDC) guidelines is the source used to keep the information concerning the risk/benefits of the vaccines and other aspects of the facility influenza program current. The signed Consent forms will be maintained by the SDC and/or DON with the flu/pneumonia vaccine log forms. 4. The DON will review the annual consents/education and the facility influenza program annually with the QA&A committee annually during the flu season from the month of October1 thru March 31. Compliance date: 12-2-11 and ongoing	

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F 334	Continued From page 28	F 334		

conducted with the Director of Nursing and Nurse Manager. They stated that the Infection Control Nurse was on leave but that they were familiar with the procedures used in administering immunizations. The Director of Nursing shared that residents are given the option of receiving the flu shot at the time of admission and again at re-admission. During the admission process, educational materials are provided to explain the risks and benefits of receiving the flu shot. The educational material was only provided during the admission and it was not offered annually because it was never brought to her attention that it had to be done that way. The Director of Nursing stated that if the expectation was to provide the education material for immunizations annually, then they have been doing it wrong for every resident.

2. Resident #2 was re-admitted to the facility on 6/28/2003. A review of her chart indicated that an influenza vaccine was administered on 9/21/2011. The last education material on file, outlining the benefits and potential side effects of the influenza immunization was signed on 10/10/2002.

On 10/21/2011 at 9:25am an interview was conducted with the Director of Nursing and Nurse Manager. They stated that the Infection Control Nurse was on leave but that they were familiar with the procedures used in administering immunizations. The Director of Nursing shared that residents are given the option of receiving the flu shot at the time of admission and again at re-admission. During the admission process, educational materials are provided to explain the risks and benefits of receiving the flu shot. The

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F 334	Continued From page 29 educational material was only provided during the admission and it was not offered annually because it was never brought to her attention that it had to be done that way. The Director of Nursing stated that if the expectation was to provide the education material for immunizations annually, then they have been doing it wrong for every resident. 3. Resident # 12 was admitted to the facility on 4/7/2010. A review of his chart indicated that an influenza vaccine was administered on 9/23/2011. The last education material on file, outlining the benefits and potential side effects of the influenza immunization was signed by the legal representative on 4/7/2010. On 10/21/2011 at 9:25am an interview was conducted with the Director of Nursing and Nurse Manager. They stated that the Infection Control Nurse was on leave but that they were familiar with the procedures used in administering immunizations. The Director of Nursing shared that residents are given the option of receiving the flu shot at the time of admission and again at re-admission. During the admission process, educational materials are provided to explain the risks and benefits of receiving the flu shot. The educational material was only provided during the admission and it was not offered annually because it was never brought to her attention that it had to be done that way. The Director of Nursing stated that if the expectation was to provide the education material for immunizations annually, then they have been doing it wrong for every resident.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

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F 356	Continued From page 30 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to include the census and breakdown of licensed staff on the daily staff posting, and failed to display the	F 356	F356 1. No residents were identified during this survey to be affected by the deficient practice. 2. Corrective action has been accomplished on 10-20-11 when the facility administrator posted in the main lobby on the baker's rack the daily nurse staffing data. This data includes the facility name, current date, total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift and resident census. 3. Measures/systems in place to ensure continued compliance are: The facility staffing coordinator and in her absence a nursing designee assigned by either the DON or administrator will post the nurse staffing data specified above on a daily basis at the beginning of each shift. This data will be visible in a prominent place readily assessable to residents and visitors, clear and in readable	

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F 356	Continued From page 31 posting in a prominent location. The findings included: On 10/18/11 at 8:15 AM, 10/19/11 at 8:00 AM, and 10/20/11 at 2:55 PM the staff posting was observed on a bulletin board hanging on the left wall of a short hall off the 200 hall. The facility had two main halls branching off the entrance lobby: the 100 hall and the 200 hall. The left side of the short hall off the 200 hall had a door to the administrator's office and a bulletin board. There were no doors off the right side of the hall. There was an exit door at the end of the hall. The staff posting lacked the resident census and breakdown of licensed nursing staff. During an interview on 10/20/11 at 3:10 PM, the administrator and director of nursing (DON) indicated they were unaware that staff posting requirements included resident census at the beginning of each shift and a separate listing for registered nurses (RNs) and licensed practical nurses (LPNs). They acknowledged that the staff posting was not in an area where residents and visitors would have a reason to go so they would not be likely to see it.	F 356	format located in the front main lobby. 4. The facility staffing will be monitored 5 times a week by the facility administrator or DON and reviewed with the QA& A Committee monthly times 3 months and then quarterly. Compliance date: 12-2-11 and ongoing.	
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		

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F 371	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label and date three small bowls of lettuce, two plates of lettuce and tomatoes, a bag of opened coconut, six small bowls of honeydew melon, three bowls of pureed peaches, five bowls of yellow pudding, three glasses of honey thickened tea, four glasses of honey thickened milk and two glasses of honey thickened cranberry juice. Findings included: Facility Policy dated 9/2008 stated: "Procedure: 12. Label and date refrigerated foods." During the initial tour on 10/18/2011, at 7:40 AM., the following items were noted to be unlabeled and undated: three (3) small bowls of lettuce and two (2) plates of lettuce and tomatoes in the walk-in cooler; a bag of coconut in the deep freezer; six (6) small bowls of honeydew melon, three (3) bowls of pureed peaches labeled with (P) and five (5) bowls of yellow pudding in the refrigerator. There were three (3) glasses of honey thickened tea, four (4) glasses of honey thickened milk and two (2) glasses of honey thickened cranberry juice that were not labeled and dated On 10/18/2011 at 7:50 AM., kitchen aide #1 stated items are usually dated when they are placed in the freezer. She stated the kitchen staff checked for expired items when they first come to work. Kitchen aide #1 did not indicate why there were undated items in the cooler and deep freezer.	F 371	F371 1. No residents were affected by alleged deficient practice. 2. The following products found to be unlabeled, undated and stored in the dietary refrigerator were removed and destroyed on 10-18-11; Three small bowls of lettuce, two plates of lettuce and tomatoes, a bag of opened coconut, six small bowls of honeydew melon, three bowls of pureed peaches, five bowls of yellow pudding, three glasses of honey thickened tea, four glasses of honey thickened milk and two glasses of honey thickened cranberry juice. 3. Systems/measures in place to ensure continued compliance are: The 1st and 2nd shift cooks will monitor for compliance all items in the department that must be labeled and dated. This will signed off twice daily, 7	

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F 371	Continued From page 33 On 10/18/2011 at 8:00 AM., kitchen aide #2 stated dietary staff pours fresh juices daily. She stated the items in the refrigerator that were undated and unlabeled must have been left from the day before and noted the date on the tray of thickened liquids as 10/16/2011. On 10/18/2011 at 8:50 AM., the Dietary Manager stated all of the items (juices, peaches, pudding, honeydew melon, lettuce, lettuce and tomato and coconut) should have been labeled and dated. He further indicated the thickened juices and milk are changed daily.	F 371	days a week on an audit tool. The Director of Dietary Services and/or the Assistant Director of Dietary Services will track the results of the above monitoring by the cooks three times a week for one month and weekly for three months. This will also be recorded on the audit tool. An in-service as conducted by the Director of Dietary Services for all dietary staff on 10-18-11 regarding the dietary requirements for proper storage of food products. 4. The Director of Dietary services will review the findings of the monitoring with the QA & A committee monthly times three months and then quarterly. Compliance date 12-2-2011 and ongoing	

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

PRINTED: 11/08/2011
FORM APPROVED
OMB NO. 0938-0391

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	345183	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/08/2011

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K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 11/8/2011 following exit discharge illumination was observed as noncompliant as the specific findings include a one bulb fixture at the exit discharge for the "A" Side. CFR#: 42 CFR 483.70 (a)	K 045	The fixture at the exit discharge for the "A" Side will be fixed by 12/5/2011. All other exterior lights will be reviewed and corrected by 12/5/2011. Any new or replacement exterior fixtures will have two bulbs. Maintenance will monitor that all exterior fixtures have two bulbs weekly for one month and will report to the QA & A committee monthly times 3 months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Lewis — TITLE: Administrator — (X6) DATE: 11/29/11

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.