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
	345329	A. BUILDING ______ B. WING ______	C 01/06/2012

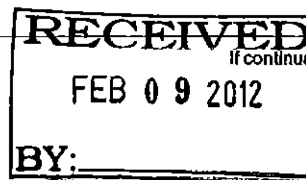
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint investigation. Event ID # Z3IL11.	F 000	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.**	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156	F 156 With regard to this alleged deficient practice, the facility has taken the following actions: 1. All residents have the potential to be affected by the deficient practice. Information on how to apply for Medicare and Medicaid benefits was posted on the informational bullentin board on 1/27/12. The Medicare denial notice with explanation/reason for Medicare benefits ending was mailed to Resident #79's responsible party on 1/30/12. Resident #79's Responsible Party had been verbally notified of the discontinuation of Medicare benefits on 7/12/11 by the Business Office Manager. 2. All residents have the potential to be affected by the alleged deficient practice. The Business Office Manager was re-educated on the process of providing the required information to residents and/or responsible party when Medicare benefits are ending by the Nursing Home Administrator on 1/30/12.	01/30/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Netta Madsen
TITLE: Administrator
(X6) DATE: 2/7/12

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

Original Signature Date: 1-31-12



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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156	3. The Nursing Home Administrator or designee will complete a Quality Improvement Monitoring Tool daily x 5 days per week x 4 weeks, then weekly x 3 months to validate appropriate notifications have been delivered to residents and/or responsible parties and Medicare/Medicaid information is continued to be posted on the information board on how to apply for Medicare and Medicaid benefits 4. The Nursing Home Administrator or Director of Nurses will report the findings of the Quality Improvement Monitoring Tool to the Quality Improvement/Risk Management Committee members monthly x 4 months to identify trends and needs for further education and/or monitoring.	

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provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record reviews the facility failed to post information for how to apply for Medicare and Medicaid benefits for all residents and failed to provide all the required information in the Medicare denial liability notices for one (1) of three (3) sampled residents. Resident #79.

The findings are:

1. Observations on 1/6/11 at 11:00 AM revealed the bulletin board located in the F hallway opposite the lobby contained informational postings for residents and families for review. Review of these postings revealed there was

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nothing posted related to how to apply for and use Medicare and Medicaid benefits.

On 1/6/11 at 11:04 AM neither the administrator nor the admissions coordinator could locate the Medicaid or Medicare information on the bulletin board. Both confirmed this was the location for resident information.

On 1/6/12 at 11:27 AM the admissions coordinator stated that she reviewed the information regarding Medicare and Medicaid with residents and families upon admission. The admissions coordinator stated that the Medicare and Medicaid information had not been posted in the four years she had been working in the facility. No explanation was provided regarding the missing postings of Medicare and Medicaid information.

2. Resident #79 was admitted to the facility on 5/11/11 under Medicare benefits. According to the notice of noncoverage letter, Resident #79's medicare benefits ended 7/15/11. Review of this letter revealed there was no explanation or reason the Medicare benefits were ending. In addition there was no evidence the notice was sent to the responsible party.

Interview on 1/5/12 at 2:43 PM with the business office manager revealed she was told by the admissions coordinator that Resident #79 was unable to sign for the notice. She stated then she waited for the family to come in and sign the notice. Per the business office manager, Resident #79 was still a resident in the facility but she still had not gotten the responsible party to sign the notification. The business office manager

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F 156	Continued From page 4 gave no explanation as to why the letter was not sent to the responsible party. In addition, the business office manager stated that when the facility started using the current notice letter (form CMS 10095), there was no place for a reason the benefits were ending so she did not add a reason.	F 156		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to plan or provide activities of interests for two (2) of three (3) sampled residents. Residents #51 and #71. The findings are: 1. Resident #51 was admitted with diagnoses including a hip fracture, acute blood loss, coronary artery disease, diabetes, chronic dysphagia, chronic obstructive pulmonary disease, benign prostatic hyperplasia, hyperlipidemia, and atrial fibrillation. Resident #51's initial activity progress notes dated 5/4/11 noted he preferred to stay in his room secondary to his medical condition. The note continued stating activity staff visit daily to	F 248	F248 1. An updated Activities Data Collection worksheet was completed for Resident #51 and Resident #71 by the Activity Director in order to provide and plan activities of interest on 1/30/12. 2. All residents have the potential to be affected by the alleged deficient practice. All current residents Activity Data Collection worksheet will be reviewed and updated on 2/2/12 as indicated in order to provide and plan activities by the Activity Director or the Activity Assistant. The Activity Director was reeducated on planning activities of interest to residents on 1/30/12 by the Nursing Home Administrator.	02/03/2012

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F 248	Continued From page 5 provide newspaper, access to snacks and conversation. This note further stated he enjoyed reminiscing about playing the guitar. An activity progress note dated 9/2/11 stated he was alert and oriented, attended occasional musical programs and listened to music in the activity room. Resident #51's (re) admission Minimum Data Set (MDS) dated 9/15/11 coded him with severe cognitive impairment, having no mood or behavior problems, and requiring extensive assistance with most activities of daily living skills (ADLs). This MDS identified the resident expressed some interests in books, newspapers, music, animals, news, outdoors, and religious activities. The Activity Plan of Care initiated 9/2/11 and reviewed 11/30/11, included a preprinted check sheet that checked current interests including animals, exercise/sports, helping others, listening to music, playing music, walking/sitting outdoors, attending religious activity, talking and watching television. The preprinted Activity plan of care checked the goals: "Resident will engage in activities of interest that are adapted to ability" and "Resident will express satisfaction with activity choices (verbal or nonverbally)". Adaptations checked included place supplies/materials to enhance ability to access and a television in room. Additional information handwritten on the activity care plan included that the focus would be on socialization due to physical limits. The handwritten goal was "Resident will engage in activity choices to meet socialization needs x 90 days" and the intervention was "adapt activity to ability,	F 248	3. The Nursing Home Administrator or Director of Nursing will review 3 resident Activity Participation Records per day to insure the residents interests are reflected on the monthly calendar. The Nursing Home Administrator will review the Activity Calendar before printing and posting monthly X 4 months to assure appropriate activities have been scheduled. The Nursing Home Administrator or Director of Nursing will monitor at least one activity 5 X per week to insure physical, mental and psychosocial needs are being met. The Nursing Home Administrator and/or Director of Nursing will complete a Quality Improvement Monitoring Tool daily X 5 days per week X 4 weeks, then weekly X 3 months to identify participation as indicated in activities of interest to residents as per their plan of care. Newly admitted residents Activity Data Collection worksheet will be completed within 5 days of admission and will be reviewed weekly at the interdisciplinary team care management meeting to insure the interests and the physical, mental and psychosocial well-being of the resident is being met by the activities being provided to them.	

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F 248	Continued From page 6 encourage participation and family visits x 90 days." Resident #51 was observed in his room with the television on all days of the survey. He was observed with his head down and not watching the television on 1/5/12 at 8:15 AM, on 1/5/12 at 11:44 AM, on 1/5/12 at 11:59 AM. Review of the Activity Participation Records for Resident #51 revealed the following: *October 2011: Resident independently participated in talking/conversing and watching television every day. *November 2011: daily group religious activity, daily talking/conversing and daily watching television. In addition he attended senior song birds on 11/1/11. *December 2011: daily talking/conversing and watching tv. In addition he attended the Christmas party on 12/20/11. Interview with the activity assistant (AA) on 1/5/11 at 4:09 PM revealed Resident #51 liked music and at one time the activity director brought him a guitar which he enjoyed picking. Per the AA, the activity director took it home and there were no other musical instruments available to residents. The AA stated Resident #51 did not attend activities. Per AA he used to come to the activity room to use the karaoke machine but that she did not take it to his room. She further stated that the activity of talking/conversing meant that nurse aides and nurses would talk to him daily and as she (the AA) passed she would see him watching television and/or be told by the nurse aides he watched television. Generally she made announcements about the activities over the	F 248	4. The Nursing Home Administrator or designee will report findings of the Quality Improvement Tool to the Quality Improvement/Risk Management Committee members to identify trends and need for further education and/or monitoring monthly X 4 months.	

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F 248	Continued From page 7 intercom and tried to invite those residents she knew would be interested in attending. She was unable to provide specific activities planned for Resident #51 and to which he was encouraged to participate to meet his interests. She further stated that she did not complete the activity forms related to resident interests, the care plans or the activity calendars The activity director was unavailable for interview. 2. Resident #71 was admitted with diagnoses including coronary artery disease, congestive heart failure, hypertension, dyslipidemia, diabetes, dementia, heart disease and lack of coordination. The (re) admission Minimum Data Set (MDS), dated 12/6/11, coded him with severely impaired cognition, no mood or behavior problems and having interests in books, magazines, music, animals, news, outdoors, and religious activities. The resident was coded as requiring limited assistance with most activities of daily living skills. The activity progress notes dated 12/6/11 stated Resident #71 was alert and oriented to self, communicated verbally, and was confused at times. This note listed his activity interests of television, sports, news, watching old movies, listening to music, and having snacks at bedside. The note stated the activity staff encouraged him to attend small groups but he usually left before the activity concluded. The Activity Care Plan initiated 12/6/11 included a preprinted check sheet that checked current interests including outdoors/walking and sitting,	F 248		

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F 248	Continued From page 8	F 248		

talking/conversation and watching television. The preprinted Activity plan of care checked the goals: "Resident will engage in activities of interest that are adapted to ability" and "Resident will express satisfaction with activity choices (verbal or nonverbally)". There were no Adaptations checked on this preprinted form. Additional information handwritten on the activity care plan included that the focus would be on socialization due to physical limits. The handwritten goal was "Resident to engage in activity of his choice which are suitable to meet socialization need x 90 days." The handwritten intervention was "adapt activity to ability, encourage interactions w/ (with) others x 90 days."

On 1/4/12 at 4:36 PM Resident #71 stated he mostly slept all day. There was no television on during this interview. Another interview on 1/5/12 at 9:59 AM he stated he likes to eat.

Resident #71 was observed in his room laying on his bed with no television on 1/3/12 at 2:47 PM; on 1/4/12 at 8:57 PM; and on 1/5/12 at 8:26 AM, at 9:59 AM, at 11:05 AM, at 12:14 PM, and at 2:16 PM.

Resident #71 was observed in the dining room eating at tables with other residents on 1/5/11 at 11:43 AM and on 1/6/12 at 7:58 AM. Observations revealed he did not converse with the resident(s) at the table with him during the meal.

Review of the Activity Participation Record for December 2011 revealed every day he participated in 2 group socials in the main dining room where there was music, every day he

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F 248	Continued From page 9 participated in talking/conversing and every day he watched television During interview with the activity assistant (AA) on 1/5/12 at 3:52 PM, the AA stated Resident #71 did not converse unless someone else initiated the conversation. Review of the activity participation records revealed Resident #71 ate in the dining room where music was played daily. She further stated that she would talk with him, asking him how he was, as she passed him daily. Either she would see the television on or staff reported the television was on daily. The AA also stated that she brought him ice cream a couple of days a week because he liked to eat ice cream. The AA also referred to a book she kept for all activities and was able to show Resident #71 participated in devotions on 12/14/11. She was unable to provide specific activities planned for Resident #71 and to which he was encouraged to participate to meet his interests. She further stated that she did not complete the activity forms related to resident interests, the care plans or the activity calendars The Activity Director was unavailable for interview.	F 248		
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 medical, nursing, and mental and psychosocial	F 279	F279 1. The care plans for Resident #51 and Resident #71 were updated to reflect measurable goals and defined interventions to insure they are congruent with residents interests and capabilities by MDS Coordinator on 1/30/12.	02/03/2012

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F 279	Continued From page 10 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 observations, staff interviews and record review the facility failed to develop individual care plans with measurable goals and defined interventions for two (2) of sixteen (16) sampled residents. Residents #51 and #71. The findings are: 1. Resident #51 was admitted with diagnoses including a hip fracture, acute blood loss, coronary artery disease, diabetes, chronic dysphagia, chronic obstructive pulmonary disease, benign prostatic hyperplasia, hyperlipidemia, and atrial fibrillation. Resident #51's activity progress note dated 9/2/11 stated he was alert and oriented, attended occasional musical programs and listened to music in the activity room. Resident #51's (re) admission Minimum Data Set (MDS) dated 9/15/11 coded him with severe	F 279	2. All residents have the potential to be affected by the alleged deficient practice. All current residents activity care plans will be reviewed and updated by 2/2/12 by the Activity Director and/or the MDS Coordinator for any corrections to insure care plans have measurable goals and defined interventions and to insure the care plans are congruent with residents interests and capabilities. 3. The Nursing Home Administrator and MDS Coordinator provided reeducation on 1/31/12 for the Activity Director to insure the Activity Director understands care plans must have measurable goals and defined interventions. MDS Coordinator will provide continued monitoring on a Quality Improvement MonitoringTool according to RAI/MDS calendar and review each activity care plan with completion of each OBRA assessment to insure care plans have measurable goals and defined interventions and to insure the care plans are congruent with residents interests and capabilities. Quality Improvement Monitoring Tool will continue weekly X 4 weeks and monthly X 3 months.	

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F 279	Continued From page 11 cognitive impairment, having no mood or behavior problems, and required extensive assistance with most activities of daily living skills (ADLs). This MDS identified the resident expressed some interests in books, newspapers, music, animals, news, outdoors, and religious activities. The Activity Plan of Care initiated 9/2/11 and reviewed 11/30/11, included a preprinted check sheet that included current interests of animals, exercise/sports, helping others, listening to music, playing music, walking/sitting outdoors, attending religious activity, talking and watching television. The preprinted Activity plan of care checked the goals: "Resident will engage in activities of interest that are adapted to ability" and "Resident will express satisfaction with activity choices (verbal or nonverbally)". Adaptations checked included place supplies/materials to enhance ability to access and a television in room. Additional information handwritten on the activity care plan included that the focus would be on socialization due to physical limits. The handwritten goal was "Resident will engage in activity choices to meet socialization needs x 90 days" and the intervention was "adapt activity to ability, encourage participation and family visits x 90 days." The care plan lacked any explanation related to how one would measure if the socialization needs were met and what exact adaptations for what activities would be provided. Resident #51 was observed in his room with the television on all days of the survey. He was observed with his head down and not watching the television on 1/5/12 at 8:15 AM, on 1/5/12 at	F 279	4. The MDS Coordinator or Administrator will report the findings of the Quality Improvement Monitoring Tool to the Quality Improvement/Risk Management Committee monthly X 4 months to identify trends and need for further education and/or monitoring.	

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11:44 AM, on 1/5/12 at 11:59 AM.

Interview with the activity assistant (AA) on 1/5/11 at 4:09 PM revealed Resident #51 did not attend activities. Per AA did not complete the activity forms related to resident interests, the care plans or the activity calendars. She was unable to state what were Resident #51's socialization needs and what activities were actually planned and or provided to meet his needs.

The activity director was unavailable for interview.

2. Resident #71 was admitted with diagnoses Including coronary artery disease, congestive heart failure, hypertension, dyslipidemia, diabetes, dementia, heart disease and lack of coordination.

The (re) admission Minimum Data Set (MDS), dated 12/6/11, coded him with severely impaired cognition, no mood or behavior problems and having interests in books, magazines, music, animals, news, outdoors, and religious activities. The resident was coded as requiring limited assistance with most activities of daily living skills.

The activity progress notes dated 12/6/11 stated Resident #71 was alert and oriented to self, communicated verbally, and was confused at times. This note listed his activity interests included television, sports,news, watching old movies, listening to music, and having snacks at bedside. Activity staff encouraged him to attend small groups but he usually left before the activity concluded.

The Activity Care Plan initiated 12/6/11 included a

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preprinted check sheet that checked current interests including outdoors/walking and sitting, talking/conversation and watching television. The preprinted Activity plan of care checked the goals: "Resident will engage in activities of interest that are adapted to ability" and "Resident will express satisfaction with activity choices (verbal or nonverbally)". There were no Adaptations checked on this preprinted form. Additional information handwritten on the activity care plan included that the focus would be on socialization due to physical limits. The handwritten goal was "Resident to engage in activity of his choice which are suitable to meet socialization need x 90 days." The handwritten intervention was "adapt activity to ability, encourage interactions w/ (with) others x 90 days." The care plan lacked any explanation related to how one would measure if the socialization needs were met and what exact adaptations for what activities would be provided.

Resident #71 was observed in his room laying on his bed with the television off on 1/3/12 at 2:47 PM; on 1/4/12 at 8:57 PM and 4:36 PM; and on 1/5/12 at 8:26 AM, at 9:59 AM, at 11:05 AM, at 12:14 PM, and at 2:16 PM. Resident #71 was observed in the dining room eating at tables with other residents on 1/5/11 at 11:43 AM and on 1/6/12 at 7:58 AM. Observations revealed he did not converse with the resident(s) at the table with him during the meals.

During the Interview with the activity assistant (AA) on 1/5/12 at 3:52 PM, the AA stated Resident #71 did not converse with people unless someone else initiated the conversation. Per AA, she did not complete the activity forms related to resident interests, the care plans or the activity

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F 279	Continued From page 14 calendars. She was unable to state what were Resident #51's socialization needs and what activities were actually planned and or provided to meet his needs. The Activity Director was unavailable for interview.	F 279		
F 280 SS=E	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 resident interviews, record reviews and staff interviews, the facility failed to include five (5) of sixteen (16) residents and/or family members to participate in the care planning	F 280	F280 1. Resident #15, #22, #102, #104 and #106 and/or responsible party for each have been invited to review the care plan with the Interdisciplinary team by the Social Services Director on or before 2/2/12. Care plans are scheduled for the week of 1/30-2/2/12 to review residents #15, #22, #102, #104 and #106 plan of care by the interdisciplinary team. 2. All residents have the potential to be affected by this alleged deficient practice. The Social Services Director was re-educated on 1/27/12 by the Nursing Home Administrator on the requirement of inviting residents and responsible parties to care plan meetings.	02/03/2012

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F 280	Continued From page 15 process. Resident # 15, #22, #102, #104, and #106. The findings were: 1. Resident #15 was assessed on her Minimum Data Sets (MDS's), an annual dated 6/14/11 and quarterlies dated 9/4/11 and 11/25/11 as being cognitively intact. Her Care Area Assessment dated 6/21/11 described her as being alert and oriented to all spheres. Review of the Care Review sheet (which identified and noted that care plans were reviewed) revealed Resident #15's care was reviewed on 9/8/11. The place to indicate the information was reviewed and provided to the resident was left blank. The Care Review sheet dated 12/1/11 noted the family declined to attend but did not indicate Resident #15 was involved in the review of the care plan. On 1/5/12 at 9:19 AM Resident #15 stated during interview that she had not attended any care plan meetings and had some care concerns to discuss including timely call bell response. She further stated she had not been invited to any care plan meetings and would like to attend. On 1/5/12 at 4:55 PM interview with the Minimum Data Set (MDS) coordinator revealed she planned the dates the care plan meetings would be held based on when assessments are due and she then sent all department heads a notice on a communication form with the date of the care plan. She further stated the social worker was responsible for inviting families and residents.	F 280	3. The Social Services Director will document the date on the Care plan calendar, provided by the MDS Coordinator, what date the resident and responsible party is invited to the care plan.. An invitation letter with the time and date of the care plan meeting will be mailed and/or given to the resident and to the responsible party and a copy of the letter placed in a Care Plan Notification Binder by the Social Services Director for future reference. The calendar will be maintained at the end of each month in the Administrators Office. The Administrator and/or the Director of Nursing will complete a Quality Improvement Monitoring Tool weekly X 4 weeks and monthly X 3 months to assure compliance that the resident and/or responsible party were invited to attend the care plan meeting. 4. The Administrator and/or the Director of Nursing will report th findings of the Quality Improvement Monitoring Tool to the Quality Improvement/Risk Management Committee monthly x 4 months to identify trends and need for further education and/or monitoring.	

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F 280	Continued From page 16 On 1/6/12 at 9:02 AM the social worker stated she had been the social worker at the facility for 8 months and was responsible for inviting families and residents to care plan meetings. She stated she invited residents after receiving a communication sheet with dates from the MDS coordinator. She further stated that alert and oriented residents were invited but that most declined to attend the care plan meeting. Regarding Resident #15, the social worker stated that the resident was very involved in her care and they talked frequently as issues arise. She further stated she does not know why Resident !5 could not recall being invited to her care plan meeting. Interview on 1/6/12 at 1:43 PM, the admissions coordinator (former social worker) stated invitations were via a spontaneous conversation, mentioned to residents in passing, i.e.. don't forget you are welcome to come. Follow up interview with Resident #15 revealed she had not been given any opportunity to discuss issues of care until the new administrator came. 2. Resident #104 was assessed on her most recent Minimum Data Set (MDS) dated 12/18/11 as having no memory or cognitive impairment (scored 15 out of 15). On 1/5/12 at 11:53 AM she stated during interview that she had not been invited to a care plan meeting since coming here and she stated she would like to attend. Review of the Care Review sheet (which	F 280		

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F 280	Continued From page 17 identified and noted that care plans were reviewed) revealed Resident #104's care was reviewed on 9/27/11, 10/6/11 and 12/22/11. The place to indicate the information was reviewed and provided to the resident was left blank. The Care Review sheet dated 12/2211 noted there was no response to care plan meeting but was not specific to the resident's response. On 1/5/12 at 4:55 PM interview with the Minimum Data Set (MDS) coordinator revealed she planned the dates the care plan meetings would be held based on when assessments are due and she then sent all department heads a notice on a communication form with the date of the care plan. She further stated the social worker was responsible for inviting families and residents. On 1/6/12 at 9:02 AM the social worker stated she had been the social worker at the facility for 8 months and was responsible for inviting families and residents to care plan meetings. She stated she invited residents after receiving a communication sheet with dates from the MDS coordinator. She further stated that alert and oriented residents were invited but that most declined to attend the care plan meeting. Regarding Resident #104, the social worker stated there have been numerous meetings with her family and the resident about the resident but not at care plan meetings. An interview was conducted on 01/06/12 at 1:43 PM with the Admissions Director who was previously responsible for inviting residents to care plan meetings prior to November 2011. She stated that she would invite residents to care plan meetings verbally in passing.	F 280		

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During a follow up interview on 1/6/12 at 1:52 PM, Resident #104 stated she was not invited to discuss her care during any care plan meeting.

3. Resident #106's admission Minimum Data Set (MDS) dated 10/7/11 coded her with having no memory and no cognitive deficits (scored a 15 out of 15).

On 1/511 at 1:56 PM Resident #106 stated she had never been invited to her care plan meetings and would like to attend with her daughter.

Review of the Care Review sheet (which identified and noted that care plans were reviewed) revealed Resident #106 had care plan meetings on 10/15/11 and 1/5/12. The place to indicate the information was reviewed and provided to the resident was left blank. The Care Review sheet dated 1/5/11 stated the residents daughter was in the facility several times a week and would bring up any issues as they arise.

On 1/5/12 at 4:55 PM interview with the Minimum Data Set (MDS) coordinator revealed she planned the dates the care plan meetings would be held based on when assessments are due and she then sent all department heads a notice on a communication form with the date of the care plan. She further stated the social worker was responsible for inviting families and residents.

On 1/6/12 at 9:02 AM the social worker stated she had been the social worker at the facility for 8 months and was responsible for inviting families and residents to care plan meetings. She stated she invited residents after receiving a

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communication sheet with dates from the MDS coordinator. She further stated that alert and oriented residents were invited but that most declined to attend the care plan meeting. Regarding Resident #106, staff stated she was alert and oriented and a care plan meeting was held this week. The social worker could not recall inviting the resident and could not explain why she had not invited the resident.

An interview was conducted on 01/06/12 at 1:43 PM with the Admissions Director who was previously responsible for inviting residents to care plan meetings prior to November 2011. She stated that she would invite residents to care plan meetings verbally in passing.

4. Resident #22 was admitted to the facility with the diagnoses edema, diabetes and atrial fibrillation. Resident #22's admission Minimum Data Set (MDS) dated 10/13/11 revealed that she was able to participate in goal setting and participated in her assessment. Her most recent quarterly MDS dated 12/13/11 revealed that she was cognitively intact.

Further review of Resident #22's medical record revealed the Care Review form dated 10/20/11 and 12/28/11 which documented care plan meetings revealed the section for resident and family participation was blank.

An interview was conducted on 01/05/12 at 10:53 AM with the Social Worker. She reported that Resident #22's family came to the care plan meeting on 12/28/11. She stated she did not invite Resident #22 to the care plan meeting

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F 280	Continued From page 20 scheduled for 12/28/11 per the family's request. An interview was conducted on 01/05/12 at 3:45 PM with Resident #22. She reported that she had never been to a care plan meeting nor had she ever been invited to one. An interview was conducted on 01/06/12 at 1:43 PM with the Admissions Director who was previously responsible for inviting residents to care plan meetings prior to November 2011. She stated that she would invite residents to care plan meetings verbally in passing. She stated she would make a mark next to the residents name on the calendar if she had notified them or the family. She was unable to recall if she had invited Resident #22 to her care plan meeting on 10/20/11. 5. Resident #102 was admitted to the facility with diagnoses of vascular dementia, and osteoarthritis. Review of Resident #102's most recent Minimum Data Set dated 10/17/11 revealed that Resident #22 had severe cognitive impairment. Further review of Resident #102's medical record revealed that care plan meetings had been conducted on 5/20/11, 10/25/11 and 12/06/11. Documentation noted on Care Review form revealed there was no documentation under the section for information reviewed with patient and family. A telephone interview was conducted on 01/04/12 at 11:40 AM with Resident #102's responsible party. She reported that she had never been invited or notified of a care plan conference since	F 280		

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F 280	Continued From page 21 the resident's admission in April of 2011. An interview was conducted on 01/05/12 at 10:50 AM with the Social Worker. She reported that letters were sent to the family to notify them of scheduled care plan meetings. She reported there was not system in place documenting if families have been notified of scheduled care plan meetings. She reported she did not know when Resident #102's last care plan meeting was or if the family was notified. An interview was conducted on 01/06/12 at 1:50 PM with the Admissions Director who was previously responsible for inviting residents and families to care plan meetings prior to November 2011. She further stated she was unable to recall if Resident 102's family was invited to any care plan meetings. An interview was conducted on 01/06/12 at 3:14 PM with Resident #102's responsible party. She reported she was never notified by letter or by phone call of a scheduled care plan meeting. She further reported she visits frequently and has wanted to schedule a meeting to discuss Resident #102's care.	F 280		
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 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	F312 1.Resident #44 and Resident #80 are being provided proper incontinent care and wipes are being disposed of after each use by Certified Nursing Assistants.	02/03/2012

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F 312	Continued From page 22 by: Based on observations, staff interviews and record review facility staff failed to discard disposable wipes after each use during observations of incontinence care in two (2) of three (3) residents. (Resident #44 and Resident #80). The findings are: 1. Resident #44 was admitted to the facility on 07/16/11 with diagnoses including rheumatoid arthritis, urinary tract infection and a stage IV sacral decubitus ulcer. The most recent Minimum Data Set (MDS) dated 12/31/11 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The resident required extensive assistance from staff for activities of daily living and was always incontinent of bladder and frequently incontinent of bowel. During an observation of incontinence care on 01/05/12 at 9:07 AM Nursing Assistant (NA) #2 and NA #3 entered the resident's room, washed their hands, and put on gloves. NA #3 removed the resident's brief that was saturated with urine. NA #3 took a single disposable wipe and wiped down the resident's right groin, then wiped down the left groin, and wiped with one stroke down the inside of the labia. NA #3 discarded the disposable wipe in a plastic bag and put a clean brief on the resident. During an interview on 01/05/12 at 9:24 AM with NA #3 she stated she was not sure when she should discard the wipes during incontinence	F 312	2. All residents have the potential to be affected by the alleged deficient practice. Reeducation on the proper technique of incontinent care and the proper disposal of wipes will be completed as of 2/2/12 with Certified Nursing Assistants. 3. Disposable wipes have been placed at bedside of all incontinent residents on 1/31/12. Observations of incontinent peri-care will be completed for 10 residents per day emcompassing all 3 shifts. 7 days per week X 4 weeks and monthly X 3 months by the Director of Nursing or Assistant Director of Nursing or Licensed Staff Nurses to insure compliance. Observation results will be documented on a Quality Improvement Monitoring Tool by the Director of Nursing or Assistant Director of Nursing or Licensed Staff Nurse. 4. The Director of Nursing or designee will report the findings of the Quality Improvement Monitoring Tool to the Quality Improvement/Risk Management Committee monthly X 4 months to identify trends and need for further education and/or monitoring.	

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F 312	Continued From page 23 care. During an interview on 01/06/12 at 12:45 PM with Licensed Nurse (LN) #1 he stated staff should discard the disposable wipes after each use. During an interview on 01/06/12 at 1:26 PM the Assistant Director of Nursing (ADON) stated disposable wipes used during incontinence care should be used once and discarded. During an interview on 01/06/12 at 1:45 PM the Director of Nurses (DON) stated she expected staff to discard the disposable wipe after they used it during incontinence care. She stated staff should not use a wipe more than once to clean a resident. 2. Resident #80 was admitted to the facility on 03/13/09 with diagnoses including congestive heart failure, dementia, and Alzheimer ' s disease. The most recent Minimum Data Set (MDS) dated 10/16/11 indicated impairment in short and long term memory and severe impairment in cognition for daily decision making. The resident was totally dependent on staff for activities of daily living and was always incontinent of bladder and bowel. During an observation of incontinence care on 01/05/12 at 3:34 PM Nursing Assistant (NA) #4 and NA #5 entered Resident #80's room, washed their hands and put on gloves. NA #4 removed the resident ' s brief that was saturated with urine. NA #5 took a single disposable wipe and wiped the resident's peri area four (4) times from front to	F 312		

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F 312	Continued From page 24 back without changing the wipe. NA #5 placed a clean brief on the resident, removed her gloves and washed her hands. During an interview with NA #5 on 01/05/12 at 3:44 PM she stated she was not sure if the wipe should be discarded after each use. During an interview on 01/06/12 at 12:45 PM with Licensed Nurse (LN) #1 he stated staff should discard the disposable wipe after each use. During an interview on 01/06/12 at 1:26 PM the Assistant Director of Nursing (ADON) stated disposable wipes used during incontinence care should be used once and discarded. During an interview on 01/06/12 at 1:45 PM the Director of Nurses (DON) stated it was her expectation for staff to discard the disposable wipe after they used it during incontinence care. She stated staff should not use a wipe more than once to clean a resident.	F 312		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**F428** 1. A pharmacy medical record review will be conducted for Resident #20 by 2/2/12.	02/03/2012

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F 428	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews the consultant pharmacist failed to complete the monthly medication monitoring reviews for one (1) of ten (10) sampled residents reviewed for unnecessary medications. (Resident #20) The findings include: Resident #20 was readmitted to the facility on 4/07/09. Her diagnoses included diabetes mellitus, psychosis, delusions, anxiety disorder, atrial fibrillation and unspecified paranoid state. A review of the monthly physician orders for Resident #20 included medications including Buspirone 2.5mg (milligram) two times daily, Zocor 10mg every day, Klonopin 1mg three times daily and Seroquel 25mg at bedtime. A continued review of the medical record revealed that Resident #20's Medication Monitoring Reviews (MMR) were completed on the following dates: January 25th 2011, February 24th 2011, March 29th 2011, April 27th 2011, May 28th 2011, June 29th 2011, July 24th 2011, August 30th 2011, September 30th 2011, October 28th 2011 and November 25th 2011. The review revealed that Resident #20's medications were not reviewed for the month of December 2011. The review revealed Resident #20's medications were not reviewed for over 40 days by the consultant pharmacist and many medication changes had been documented during this review period. An interview with the director of nursing (DON) on 1/6/12 at 10:05 AM revealed that the consultant	F 428	2. All residents have the potential to be affected by the alleged deficient practice. The Consultant Pharmacist was re-educated on 1/9/12 by the Director of Nursing that all residents must have their drug regimen reviewed at least once per month. To assure compliance, during the Consultant Pharmacist monthly visit a resident census listing will be provided to her upon entrance for her to review and assure each resident's drug regimen is reviewed monthly. The Consultant Pharmacist will provide a census listing of the residents that were reviewed at the facility exit on that date. The Administrator and/or Director of Nursing will review the resident census listing to assure the Consultant Pharmacist completed the review of all residents due for a drug regimen review for the month. 3. The Director of Nursing or designee will complete a Quality Improvement Monitoring Tool to monitor compliance at the end of each month x 4 months to insure Consultant Pharmacist has reviewed all residents. The Director of Nursing or designee will review the Consultant Pharmacist's resident census listing of the residents drug regimen reviewed vs the current resident census for the month. The Director of Nursing or Assistant Director of Nursing will	

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F 428	Continued From page 26 pharmacist was always given a census of the residents to be reviewed during the monthly pharmacy review visit. The DON stated that the pharmacist usually came at the end of the month and her last visit would have been at the end of December 2011. The census list provided to the consultant pharmacist by the DON during the December 2011 visit did have the name of Resident #20 listed but her name was not included as a resident reviewed by the pharmacy consultation report. The DON was not sure why Resident #20's medications were not reviewed during the month of December 2011 and confirmed that Resident #20 was not out of the facility during that monthly pharmacy review. A telephone interview with the consultant Pharmacist, on 1/6/12 at 12:15 PM revealed that she had missed to review the medications for Resident # 20 in the month of December 2011 while she was in the building. The pharmacist stated that this was 'overlooked' at the time of December 2011 reviews. The pharmacist also confirmed that her next visit would have been at the end of January 2012.	F 428	review each medical record for documentation of monthly pharmacy review. Quality Improvement Monitoring Tool will document the monthly resident record drug regimen review to insure compliance and will be completed by the Director of Nursing or Assistant Director of Nursing. 4. The Director of Nursing and/or designee will report the findings of the Quality Improvement Tool to the Quality Improvement Risk Management Committee monthly x 4 months to identify trends and need for further education and/or monitoring.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F441 1. Resident #44, Resident #80 and Resident #122 soiled linens are being disposed of properly. Staff are washing their hands and removing their gloves appropriately for Resident #44, Resident #80 and Resident #122.	02/03/2012

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F 441	Continued From page 27 In the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (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 record reviews facility staff failed to properly dispose of soiled linen and failed to remove gloves and wash hands after providing incontinence care for three (3) of three (3) residents observed. (Resident #44, Resident #80 and Resident #122). A review of a facility policy dated 02/09 and titled	F 441	2. All residents have the potential to be affected by this alleged deficient practice. Nursing Staff have been reeducated on hand washing policy/procedure and the proper handling of soiled linens policy/procedure on or before 1/31/12. 3. The Director of Nursing or Assistant Director of Nursing or Licensed Staff Nurse will complete a Quality Improvement Monitoring Tool to monitor compliance regarding hand washing and disposing of soiled linens. Quality Improvement Monitoring Tool will document the observation of Certified Nursing Assistants providing care to 10 residents daily which will emcompass all 3 shifts 7 days per week X 4 weeks and thereafter; monthly X 3months. 4. The Director of Nursing and/or Administrator will report the findings of the Quality Improvement Tool to the Quality Improvement/Risk Management Committee monthly X 4 months.	

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"Bloodborne Pathogens" stated to wear appropriate gloves when it can be reasonably anticipated that there will be contact with blood or body fluids and when handling or touching contaminated items or surfaces. Replace gloves if contaminated.

The findings are:

1. During an observation of incontinence care on 01/05/12 at 9:07 AM Nursing Assistant (NA) #2 and NA #3 entered Resident #44's room, washed their hands, and put on gloves. NA #3 removed the resident's brief that was saturated with urine and provided incontinence care. NA #3 turned Resident #44 toward her right side and NA #2 pulled the soiled linen and the wet brief from under the resident and placed it directly on top of a fall mat on the floor next to the resident's bed. NA #3 with her gloves still on, put a clean brief on the resident, straightened the sheets on the bed, straightened the resident's gown and put a blanket over the resident.

During an interview with NA #2 on 01/05/12 at 9:20 AM she verified she placed the soiled linen directly on the fall mat on the floor because she did not have a plastic bag to put it in. She stated she was aware she should have had a plastic bag available but she forgot to get one before they started care.

During an interview with NA #3 on 01/05/12 at 9:24 AM she stated she should have removed her gloves after she provided incontinence care and she should have removed her gloves before she touched clean linens and the resident's clothing.

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F 441	Continued From page 29 During an interview on 01/06/12 at 12:45 PM Licensed Nurse (LN) #1 who was also in charge of infection control stated staff should not put soiled linens directly on the floor or on top of fall mats. He further stated nursing staff should change their gloves after they finished incontinence care, wash their hands and put on clean gloves prior to putting on a clean brief. He stated nursing staff should not touch any clean items with their soiled gloves still on. During an interview on 01/06/12 at 1:26 PM the Assistant Director of Nurses (ADON) stated soiled linens should not be placed directly on the floor and it should always be bagged and taken to the soiled linen room. She stated nursing staff should always remove their gloves after they finish a dirty job and before starting a clean job. She explained staff should not touch clean linens or other clean items with their soiled gloves still on. During an interview on 01/06/12 at 1:45 PM the Director of Nurses (DON) stated she expected staff to put soiled linens in a plastic bag and they should not put soiled linen directly on the floor or on top of a fall mat. She stated staff should remove their gloves after incontinence care and before they touched any clean items in the resident's room. 2. During an observation of incontinence care on 01/05/12 at 3:34 PM Nursing Assistant (NA) #4 and NA #5 washed their hands and put on gloves in Resident #80's room. NA #4 picked up a stack of disposable wipes that were unpackaged and lying on a roommates overbed table and placed them on top of Resident #80's bed. NA #4	F 441		

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F 441	Continued From page 30 removed the resident's brief that was saturated with urine and picked up one of the disposable wipes and provided incontinence care. NA #5 picked up a clean brief with her gloves still on a placed it on the resident. NA #5 placed the clean pants on the resident, straightened the resident ' s clothing and sheets on the bed, went into the resident's closet to get a pair of shoes and put them on the resident. NA #5 with her gloves still on moved a wheelchair into position next to the resident's bed and NA #5 transferred the resident to her wheelchair with her gloves still on. NA #5 straightened the linens on the bed, picked up the pillows and placed a blanket on the resident's bed. During an interview on 01/05/12 at 3:44 PM with NA #5 she stated some residents had their own containers of disposable wipes and they kept wipes on the linen cart to use for resident's who did not have them. She further stated she should not have taken the wipes from the overbed table and placed them on the resident's bed. NA #5 verified she did not remove her gloves after she provided incontinence care to Resident #80 and stated she should have removed her gloves and washed her hands before she touched any clean items in the resident's room. During an interview on 01/06/12 at 12:45 PM with LN #1 who was also in charge of infection control stated nursing staff should change their gloves after they finished incontinent care and wash their hands and put on clean gloves prior to putting on a clean brief. He further stated nursing staff should not touch any clean items with their soiled gloves still on.	F 441		

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F 441	Continued From page 31 During an interview on 01/06/12 at 1:26 PM the Assistant Director of Nurses (ADON) stated nursing staff should always remove their gloves after they finished incontinence care and staff should not touch clean linens or other clean items with their soiled gloves still on. The ADON stated wipes that had been taken out of their package and taken into a resident's room should be used only for one resident and any left over wipes should be discarded. During an interview on 01/06/12 at 1:45 PM the Director of Nurses (DON) stated she expected staff to remove their gloves after incontinence care and before they touched any clean items in the resident's room. She stated wipes that left over after care was completed should be discarded and not used on another resident. 3. An observation was made on 01/06/12 at 9:18 AM of Nursing Assistant (NA) #1 providing incontinence care for Resident #122. When Resident #122 had finished using the commode NA #1 donned gloves. She assisted the resident to stand and hold to the bar in the bathroom while she cleaned him. NA #1 cleaned his groin and buttocks. Without removing her gloves, NA #1 pulled up Resident #122's clean pants and clean incontinence brief. NA#1 then positioned the resident's wheel chair touching the arm rests and handles with her gloves. After positioning Resident #122 in the wheel chair NA #1 removed her gloves. An interview was conducted 01/06/12 at 12:45 PM with Licensed Nurse (LN) #1 who is charge of	F 441		

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F 441	Continued From page 32 infection control surveillance. LN #1 reported staff needed to change their gloves after incontinence care once the soiled incontinence brief was discarded prior to putting on the clean brief or touching any other clean object. An interview was conducted on 01/06/12 at 1:26 PM with the Assistant Director of Nursing. She reported that gloves should be changed after incontinence care prior to touching anything that is clean. An interview was conducted 01/06/12 at 1:45 PM with the Director of Nursing. She stated she expected staff to remove their gloves during incontinence care after they cleaned the resident and before they touched any clean items in the resident's room. An interview was conducted on 10/06/12 at 2:00 PM with Nursing Assistant (NA) #1. She reported that she should have taken off the dirty gloves before putting on Resident #122's clean clothes or touching his wheel chair.	F 441		