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
	345462	A. BUILDING ______ B. WING ______	C 04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on family, resident and staff interviews the facility failed to answer call bells for 45-50 minutes for two (2) of seven (7) residents observed for call bell response time. (Residents #7 and #47). The findings are: 1. Resident #47 was admitted to the facility with the diagnoses of diabetes mellitus, end stage renal disease and legal blindness. Review of Resident #47's most recent Minimum Data Set (MDS) dated 4/24/12 revealed she had mild cognitive impairment. The MDS further assessed Resident #47 as having highly impaired vision. Further review of the MDS revealed she needed extensive assistance with toileting and personal hygiene and was always continent of bowel and bladder. Review of Resident #47's care plan dated 4/19/12 revealed she had the potential for injury from falls related to unsteady gait weakness and poor vision. Interventions in place were to remind her to call for assist with transfers or ambulation and to keep her call light within reach. An interview was conducted on 4/25/12 at 12:12	F 241	F241 Residents #7 and #47 have and will continue to have their call bells answered in order to meet their needs. All residents have the potential to be affected by the same deficient practice. A 100% in-service of all staff regarding response to call bells was performed by the Administrator on May 17, 2012. Staff that were not able to attend the mandatory meeting was in -serviced via telephone by May 21, 2012. Monitoring of the response to call bells will occur by Nurse Managers, Weekend Supervisor and Director of Health Services daily	5/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Whitlock
TITLE: Administrator
(X6) DATE: 5/18/12

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.

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MAY 30 2012
BY: DRH

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F 241	Continued From page 1 PM with Resident #47's family. The family member reported last week while visiting the resident he waited forty-five (45) minutes for someone to answer the call bell to take her to the bathroom. The family member stated he finally went to the nurse's station and asked the nurse sitting at the desk to help. The next night the family member stated he waited for fifty (50) minutes for the call bell to be answered to take his the resident to the restroom. He said he finally took her to the restroom himself and cleaned her up. The family member stated the resident was able to use the restroom on her own she just needs assistance getting there. An interview was conducted on 4/27/12 at 8:10 AM with the Director of Health Services. She reported it is her expectation that call bells should be answered as soon as possible but no longer than fifteen (15) minutes. She stated that if nurses hear the call bell she expects them to answer if a nursing assistant is not available or is busy. An interview was conducted on 4/27/12 at 8:25 AM with the Administrator. She stated it was her expectation that the nurse sitting at the desk would answer the call light. She further stated she would expect someone to wait no more than fifteen (15) minutes for a call bell to be answered. An interview was conducted on 4/27/12 at 8:37 AM with the Unit Nursing Manager #1. She reported Resident #47's family voiced a concern that he had to wait forty-five (45) minutes and longer the next night for someone to answer the resident's call bell. She stated he told the nurse he had finally taken the resident to the bathroom	F 241	for two (2) weeks, then weekly for two (2) weeks. Monitoring will continue monthly for two (2) months. Results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee monthly by Director of Health Services for recommendations and suggestions for (3) months.	5/25/12

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F 241	Continued From page 2 because staff did not answer the call bell. She stated her expectation was for call bells to be answered within fifteen (15) minutes or as soon as possible. 2. Resident #7 was admitted to the facility with the diagnoses diabetes mellitus, chronic kidney disease and legal blindness. Review of Resident #7's most current Minimum Data Set (MDS) dated 4/10/12 revealed he had significant cognitive impairment. The MDS further assessed Resident #7 as needing extensive assistance for toileting and his vision was highly impaired. Review of Resident #7's care plan dated 4/10/12 revealed he had a self care deficit for activities of daily living and needed assistance with toileting related to his blindness. The goal was that Resident #7 would be kept clean, dry and comfortable. Interventions included staff were to anticipate and meet his needs, maintain hygiene and skin integrity. Resident #7 was also care planned for falls as he had the potential for injury related to his blindness, muscle weakness and cognitive decline. The goal was to minimize injury from falls by keeping the call light in reach and telling him where it was located. An interview was conducted on 4/25/12 at 12:32 PM with Resident #7's roommate who was Resident #5. (Review of Resident #5's most recent MDS dated 2/10/12 revealed he was cognitively intact.) Resident #5 reported that Resident #7 kept him up all night the night before as he yelled for over thirty (30) minutes to go to the bathroom. He reported that he turned on his call bell as his roommate could not find his most	F 241		5/25/12

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F 241	Continued From page 3 of the time due to his blindness. He reported he finally had to get up and go out into the hall to try to find someone to help as his roommate was trying to get out of bed. An interview was conducted on 4/27/12 at 8:10 AM with the Director of Health Services. She reported it is her expectation that call bells should be answered as soon as possible but no longer than fifteen (15) minutes. She stated if nurses heard the call bell she expects them to answer if a nursing assistant was not available or busy. An interview was conducted on 4/27/12 at 8:16 AM with the Administrator. She reported that Resident #5 had reported the situation to her. She further stated that she expects staff to go immediately to assist that resident. She stated residents should not have to wait more than fifteen (15) minutes for call bells to be answered.	F 241		5/25/12
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of Resident Council meeting minutes, resident interview and staff interviews, the facility failed to resolve issues regarding call bell response and staff's usage of cell phones repeatedly discussed in Resident Council	F 244	F244 There were no named Residents in this citation. All Resident Council (RC) issues will be addressed with satisfactory resolution. A 100% in-service of all Department Managers was held by the Administrator	5/25/12

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F 244	Continued From page 4 meetings over the last five (5) of six (6) months. The findings are: Review of the Resident Council Meeting minutes revealed the following concerns and written responses: *On 11/11/11 residents expressed concerns regarding call lights not being answered timely. The written response indicated that nursing staff were spoken to regarding call light response. *On 12/9/11 residents expressed concerns regarding call bells not being answered timely. The written responses included a verbal discussion was held-no further details. *On 1/13/12 residents expressed concerns regarding call lights not being answered timely. The written response from the Director of Health Services included an inservice was planned for the nursing department scheduled for 1/19/12. *On 2/10/12 residents expressed concerns regarding call bells not being answered timely and nurse aides texting on their personal phones while providing care. The written response from the Director of Health Services included that an inservice was held with the nurse aides regarding phone usage and answering call bells. The nurse manager was to monitor. *On 3/9/12 residents expressed concerns regarding call bells not being answered timely and nurse aides texting on their personal phones while providing care. The resident council requested the Director of Health Services attend the next meeting. The written response from the Director of Health Services was that an inservice was held and all issues were addressed and nurse management was to monitor. *On 4/13/12 residents expressed concerns	F 244	on May 21, 2012. Staff was in-serviced on how to respond to Resident Council meeting issues with final review of all concerns approved by the Administrator prior to the Resident Council meetings. Response/resolution to the Resident Council concerns/grievance will be monitored by Activity Director monthly for three (3) months Results of the follow up to Resident Council concerns/grievances monitoring with tracking and trending will be reported to the Performance	5/25/12

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F 244	Continued From page 5 regarding call bells not being answered timely and nurses aides texting on their personal phones while providing care. The written response from the Director of Health Services (DHS) was that the DHS spoke with the resident council, monitoring was being done by the DHS and nurse managers and employees using their phones will be spoken to by the DHS and nurse managers. Interview on 4/25/12 at 5:15 PM with Licensed Nurse (LN) #4 revealed she had worked Saturday and Sunday from 6:00 PM until 6:00 AM until recently when she moved to a different nursing unit. She explained staff were "on the go the whole time we're on duty" and response times to call bells varied because if all staff were providing care to residents someone might have to wait until staff were available to assist them. She explained nursing assistants usually responded to the call bells and if they were busy with resident care, the nurse would answer the call bell. Interview on 4/26/12 at 2:35 PM with the Unit Nurse Manager #2 on East Wing revealed there was no formal monitoring of call bell response and that she "is mindful" of getting call bells answered timely. She further stated there was no specific directive related to monitoring of call bell response. Interview with the Resident Council President on 4/27/12 at 8:22 AM revealed the residents bring up the same issues at each meeting including call bell response and texting by nurse aides but these have not been fixed. The president further stated the information related to follow up is reviewed at the next month's meeting but either	F 244	Improvement Committee by Activity Director for suggestions and recommendations monthly for three (3) months.	5/25/12

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F 244	Continued From page 6 the response has been inadequate or no improvement has been seen. On 4/27/12 at 9:13 AM the Activity Director (AD) stated when issues are brought up in resident council, she filled out a form with the concern and gave the concern to the appropriate department head for a response. The department head then completed the form, the administrator signed it and the form was returned to the AD so she could review it a the next Resident Council Meeting. The AD stated there was a repeat of resident concerns involving call bell response and staff being on the phone during care. On 4/27/12 at 11:58 AM, the Administrator stated they have tried to address customer service via an inservice on 3/13/12 and a retreat on 3/14/12. On 4/27/12 at 12:57 PM the DHS stated and provided a time line of what she implemented to address the Resident Council concerns as follows: *in January 2012 a staff inservice was scheduled and DHS and Assistant DHS were to monitor and address with staff as incidents occur; *in February 2012 the facility hired new managers to monitor call bell response and phone usage and there was a plan for all managers from all departments to help answer call lights with ongoing monitoring; *in March 2012 staff were informed that call light answering and phone usage was still a concern and management continued to monitor; *in April 2012 planned for a nurse manager to be placed on each wing and another nurse aide to be hired for each wing to act as a coordinator to help answer lights and monitor phone usage.	F 244		5/25/12

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F 244	Continued From page 7 The DHS was unable to provide evidence or explanation of the monitoring system in place to monitor call bell response or nurse aides using cell phones during resident care. Interview on 4/2712 at 4:45 PM with Unit Nurse Manager #1 stated staff have had inservice's recently regarding timely response to answering call bells. She stated anybody could answer a call bell and get help from a nurse if needed. She explained the Director of Health Services has stated her expectations for Unit Nurse Managers to monitor call bell responses but she verified she did not document any quality improvement data or information to track numbers of call bells or response times.	F 244		5/25/12
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, policy review and staff interviews, the facility failed to label and store personal care equipment in a sanitary manner, off direct contact with the floor. This was observed on two (2) of five (5) halls. The findings are: Review of the facility's policy dated August 1996 "Bedpans and Urinal: Labeling, Storing and Cleaning" stated "The bedpan or urinal will be labeled and stored in a plastic bag in the	F 253	F253 There were no named Residents in this citation. All Residents' personal care equipment will be labeled and stored in a sanitary manner in plastic bags in the bathroom or bedside cabinet. 100% of all nursing and housekeeping staff was in-serviced on May 17, 2012.	5/25/12

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F 253	Continued From page 8 patient/resident's closet, bedside stand, on a shelf in the patient/resident's bathroom or hanging on handrail in the bedroom. Bedpans and urinals will not be stored on the floor or near "clean" patient/resident care items. During environmental tours on 4/23/12 beginning at 2:23 PM, on 4/25/12 beginning at 4:50 PM and on 4/27/12 beginning at 10:40 AM the following personal care items were observed as follows: *Room 303: a wash basin was on the bathroom floor behind a plastic set of shelving. *Room 311: two unlabeled wash basins were stacked together with a used washcloth and fracture pan inside the top wash basin on the bathroom floor. *Room 309: an unlabeled wash basin was on the bathroom floor. *Room 305: a wash basin was on the shower floor. *Room 206: there were four washbasins on the bathroom floor. Two wash basins were stacked inside each other, one was labeled "wound" and had an emesis basin inside with another washbasin stacked on top. Another wash basin with crushed sides had another wash basin inside of it. All items had soap-like residue inside. *Room 205: a wash basin was on the bathroom floor. On 4/27/12 at 10:44 AM, nurse aide (NA) #3 stated used items such as wash basins were to be rinsed and placed in the resident's dresser drawer or bagged in the bathroom. NA #3 stated these personal care items should not be placed on the floor. On 4/27/12 at 2:40 PM interview with the unit	F 253	Staff not able to attend was in-serviced via telephone by May 21, 2012. Monitoring of the proper labeling cleaning and storage of personal equipment will occur by Director of Housekeeping Services and Unit Managers weekly for one (1) month then bi-weekly for two (2) months. Results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Unit Managers for recommendations and suggestions monthly for three (3) months.	5/25/12

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F 253	Continued From page 9 nurse manager #2 revealed all used personal care equipment should be labeled and bagged. When asked about storing them on the floor she stated she was not sure. On 4/27/12 at 1:00 PM interview with the Director of Health Services (DHS) stated she was not sure about the storage of equipment and would have to get the policy. On 4/27/10 at 5:30 PM the Administrator stated the wash basins should be labeled and stored in a bag and not kept on the floor. She further stated that rounds were made daily to check for things like unlabeled inappropriately stored wash basins.	F 253		5/25/12
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 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	F 279	F279 Resident #18 had the use of adaptive feeding equipment added to their plan of care by the Case Mix Director on May 17, 2012. All Residents with adaptive feeding equipment will have their plan of care reviewed on May 17, May 18, May 21,	5/25/12

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F 279	Continued From page 10 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to include adaptive eating equipment on the care plan and with the care plan review for one (1) of one (1) sampled residents. Resident #18. The findings are: Resident #18 was admitted to the facility on 1/6/12 with diagnoses including late effective intracranial injury and muscle weakness. Review of Occupational therapy (OT) notes dated 1/13/12 revealed Resident #18 was assessed for using weighted utensils. OT notes dated 1/17/12 stated Resident #18 was seen for self feeding. A weighted spoon was tried with less spillage noted. Then a bendable spoon for left hand was tried with greater success. This note indicated a communication was sent to the dietary department for a lipped plate and bendable spoon for all meals. This communication form was dated 1/17/12. The admission Minimum Data Set (MDS) dated 1/18/12 coded Resident #18 as having intact cognition and requiring set up and supervision for eating. The Care Area Assessment dated 1/24/12 assessed Resident #18 as feeding himself and receiving therapy services.	F 279	and May 22, 2012 to ensure that the adaptive devices are noted on the Plan of Care. 100% of all licensed nurses will be in-serviced on adding the use of adaptive equipment to the plan of care by the Director of Health Services by May 17, 2012. Staff not able to attend were in-serviced via telephone by May 21, 2012. Monitoring to ensure adaptive equipment has been added to the plan of care will occur by Case Mix Director weekly for two (2) weeks, then bi weekly for two (2) weeks. Monitoring will continue	5/25/12

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F 279	Continued From page 11 Review of the care plans originally developed 1/18/12 and last updated 4/17/12 for activities of daily living skills and for nutrition did not have any interventions related to eating equipment. Review of the quarterly MDS dated 4/16/12 revealed Resident #18 required limited assistance with eating. Observation of Resident #18's tray cards revealed a left handed bent spoon was listed to be placed on his tray. Observations revealed Resident #18 did not receive the left handed bent spoon on 4/25/12 at 8:16 AM, 4/25/12 at 12:50 PM and 4/26/12 at 12:48 PM. Interview with the MDS coordinator on 4/27/12 at 10:00 AM revealed she did not complete the first care plan but should have caught the need for the adaptive equipment and updated the care plan in April.	F 279	to occur monthly for two (2) months. Reporting of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Case Mix Director for recommendations and suggestions monthly for three (3) months.	5/25/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to do an initial admission nursing assessment and a fall risk assessment on a resident identified at risk for falls for one (1) of four (4) sampled residents. (Resident #170). The findings are:	F 281	F281 Resident #170 no longer resides at the facility. All newly admitted Residents' will have their initial admission nursing assessment and fall risk assessment as indicated completed with the	5/25/12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 A review of a facility document titled "Admission Assessments" with a revised date of 4/03 indicated under Policy: "The licensed nurse will complete the Admission/Nursing Evaluation Form on admission. The Comprehensive care Plan will be based in part on this assessment." A review of a facility document titled "Fall Risk Assessment" with a revised date of 2/10 indicated under Guideline: "All patients/residents will be assessed on admission, re-admission, significant change in condition, and at least quarterly. Patients/residents who score (10) or more, interventions should be promptly put in place." Resident #170 was admitted on 4/6/12 at 2:39 PM with diagnoses including a urinary tract infection, generalized muscle weakness, osteoporosis, high blood pressure, asthma, anxiety and depression. Resident #170 was transferred to the hospital on 4/9/12 due to increased confusion and a fall from a wheelchair with moderate right (R) foot pain. A review of a history and physical dated 4/3/12 indicated Resident #170 was seen at the hospital emergency room on 3/26/12 for complaints of left (L) hip and back pain and she had a history of osteoporosis and fractures in her spine. She returned to the hospital emergency room on 3/29/12 with altered mental status and weakness. She returned to the emergency room again on 3/31/12 after a fall at home and was not able to explain where or how she injured herself. In the emergency room, her neck and hip were x-rayed, no acute injuries were found and she was sent home. She returned again to the emergency	F 281	admission process. 100% of all licensed nurses will be in-serviced by May 17, 2012 on completing the initial nursing assessment and other admission assessments as indicated. Staff not able to attend was in-serviced via telephone by May 21, 2012. All newly admitted Residents medical record will be audited within 24 hours of admission to ensure all assessments as indicated have been completed by Unit Managers and Weekend Supervisors .Monitoring of the results of the 24 hour audit will occur by Unit Managers and Weekend Supervisor weekly for four (4) weeks,	5/25/12

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F 281	Continued From page 13 room on 4/1/12 with a fever and confusion and was admitted to the hospital on 4/2/12 with altered mental status and a urinary tract infection. A review of a "Hospital Report Form" dated 4/6/12 indicated "Does the patient/resident have a Fall Risk (Complete Fall Risk Assessment)" and an "x" was marked in the box for "yes." A review of a document titled "Body Audit Form" indicated a hand written note "charting for 4/6/12" but signed and dated on 4/10/12. The document further indicated Resident #170's generalized skin color was normal and warm and the resident had band aids between the toes on her (R) foot, a bandage over a skin tear on her (L) elbow and two (2) bandages that were dry and intact on her (R) arm reported as skin tears by family acquired at the hospital. A review of an "Admission/Nursing Evaluation Form" indicated there were a total of 31 assessment sections and a signature page at the end of the document for staff to sign when they completed sections of the form. The signature page indicated sections 3-31 were completed on 4/9/12 by Licensed Nurse (LN) #6: Section 3: Level of Consciousness Section 4: Memory Section 5: Sleep Pattern Section 6: Patient/Resident's Demeanor Section 7: Communication/Sensory Section 8: Head/Face Section 9: Neck Section 10: Oral Section 11: Neurological Section 12: Mobility/Ambulation/Musculoskeletal Section 13: Respiratory/Chest	F 281	then bi weekly for one (1) month and monthly for one (1) month. Tracking and trending of the Results of the monitoring with reporting to the Performance Improvement Committee will occur by Unit Managers for recommendations and suggestions monthly for three (3) months.	5/25/12

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F 281	Continued From page 14 Section 14: Breasts Section 15: Cardiovascular Section 16: Abdomen Section 17: Toileting Section 18: Bladder Section 19: Bowel Section 20: Foot Assessment Section 21: Dressing/Grooming/ADL Section 22: Transferring Section 23: Eating Section 24: Hydration Section 25: Medication Review Section 28: Special Need Section 29: MD names Section 30: Interim Care Plan Section 31: Other Information A review of Section 26 titled "Body Audit" and Section 27 titled "Braden Scale For Predicting Pressure Sore Risk" on The Admission/Nursing Evaluation Form indicated both sections were completed by a wound care nurse on 4/9/12. Section 26 further indicated Resident #170's body assessment revealed a light red bruise to her throat, dark red/purple bruises to entire bilateral arms and hands, multiple small bruises to the shin on her (R) leg, a big red/purple bruise on the shin of her (L) leg, and skin tear on the back of her right wrist and redness on her buttocks. A statement at the bottom of the signature page of the Admission/Nursing Evaluation Form indicated the document was reviewed and signed by the Unit Manager on 4/11/12. A review of Section 30 titled "Interim Care Plan" on the Admission/Nursing Evaluation Form indicated there was a blank check box next to a statement "Completed and placed under CP	F 281		5/25/12

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F 281	Continued From page 15 (care plan) section of chart." A review of an Emergency Medical Services (EMS) report dated 4/9/12 at 6:19 PM indicated Resident #170 "had a fall earlier from a sitting position. No head injury. Patient usually alert and oriented. Patient's (R) leg edematous and swollen. Patient complaining of (R) hip pain. Patient has history of Urinary Tract Infection last week and upper limbs have new bruising since last night." During a phone call on 4/24/12 at 8:39 AM the Primary Complainant stated Resident #170 expired at the hospital on Monday morning 4/23/12 at approximately 2:30 AM. During an interview on 4/25/12 at 5:15 PM Licensed Nurse (LN) # 4 stated she took care of Resident #170 on Saturday 4/7/12 and Sunday 4/8/12 from 6:00 PM to 6:00 AM and remembered the resident was confused. She explained Resident #170 kept trying to get out of bed and they had to remind her to use her call bell to call for help. She stated she did not do an initial nursing assessment or a fall risk assessment because the resident had been admitted during the day on Friday 4/6/12 and she didn't realize it hadn't been done. During an interview on 4/26/12 at 9:54 AM with LN #5 who was also a Wound Care Nurse stated she did not see Resident #170 until Monday 4/9/12 between 3:30 and 4:00 PM and verified she did Section 26 "Body Audit " and Section 27 for the Braden Scale on the Admission/Nursing Evaluation Form. She stated it was routine practice in the facility for the Wound Care Nurse	F 281		5/25/12

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F 281	Continued From page 16 to complete sections 26 and 27 of the form and she further stated she did not do any other sections of the nursing assessment. She explained she was told on Monday 4/9/12 Resident #170 had a fall from her wheelchair earlier in the day and she went to assess her skin. She verified Resident #170 had bruises from both upper arms down to her hands and her skin was very fragile on her arms and she had a skin tear on her right wrist. She stated Resident #170's buttocks were also red but she did not see any skin breakdown. During an interview on 4/26/12 at 10:28 AM with LN # 2 she verified she completed the Hospital Report Form on 4/6/12 when a nurse at the hospital called and gave information about Resident #170 before she came to the facility. She further verified she was told the resident was a fall risk and she documented the "x" in the box for "yes" on the form. She stated she did not take care of Resident #170 until Monday 4/9/12 and assessed her after she fell out of her wheelchair that day. She explained Resident #170 kept trying to get out of bed so they got her up in a wheelchair and placed her in the hallway outside her room so staff could watch her but she leaned forward in her wheelchair and tipped over. She stated she was not sure why an admission assessment or a fall risk assessment was not done when Resident #170 was admitted. She explained the initial nursing assessment was supposed to be done after the resident was admitted and she always tried to do the body assessment and a nurse's note "right away" but she stated "everyone did it differently." During an interview on 4/26/12 at 10:50 AM with	F 281		5|25|12

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F 281	Continued From page 17 LN #6 he stated he worked on Monday 4/9/12 and reviewed several charts of new admissions as part of his quality assurance (QA) duties and found the initial nursing assessment on the Admission/Nursing Evaluation Form had not been done for Resident #170 and he completed sections 3-31 on the form. He stated he did not know why it wasn't done and explained the initial nursing assessment should have been done within the first twenty-four (24) hours of admission and the initial skin assessment should have been done within eight (8) hours after admission. LN #6 verified there was no fall risk assessment in Resident #170's chart and there was no documentation on a care plan or other documents regarding whether the resident had an alarm or other fall prevention interventions while she was in the facility. He further verified Resident #170 had a fall from her wheelchair on 4/9/12 and was transferred to the hospital during the evening of 4/9/12. During an interview on 4/26/12 at 11:20 AM Unit Nurse Manager #1 stated she first saw Resident #170 on Saturday 4/7/12 but she did not document a nursing assessment and did not realize the initial nursing assessment or fall risk assessment had not been done. She stated she was off work from Sunday 4/8/12 through Tuesday 4/10/12 and when she came back to work she was told Resident #170 went to the hospital. Unit Nurse Manager #1 verified the "Hospital Report Form" indicated Resident #170 was a fall risk and verified there was not a Fall Risk Assessment in the resident's medical record. She stated the initial nursing assessment and a fall risk assessment should have been done within twenty-four (24) hours after Resident	F 281		5/25/12

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F 281	Continued From page 18 #170 was admitted and there should have been documentation of fall risk interventions for the resident. During an interview on 4/26/12 at 4:46 PM with LN #7 she explained Resident #170 was admitted to the facility on Friday afternoon 4/6/12 and family members were with her. She stated the resident's family left around 5:30 PM and Resident #170 had increased anxiety around 9:30 PM and kept calling for assistance to the bathroom. She explained she went into the resident's room with a single page document titled "The Body Audit" form to do a skin assessment on Resident #170. She explained "The Body Audit Form" she had was similar to the one in the Admission/Nursing Evaluation Form but it was shorter and sometimes she filled it out until she had time to do the full assessment. She verified she did not do an initial nursing assessment or fall risk assessment because Resident #170 was agitated and said she didn't want to be bothered. During a follow up interview on 4/26/12 at 5:22 PM with LN #7 she explained when she returned to work on 4/10/12 the Director of Health Services (DHS) asked her where the Body Audit Form for Resident #170 was and she stated she told her she had done one but they could not find it. She stated she filled out another Body Audit Form from memory and wrote the note "charting for 4/6/12" and dated the form 4/10/12. During an interview on 4/27/12 at 5:06 PM the Director of Health Services (DHS) stated it was her expectation the initial nursing assessment and Fall Risk Assessment should be done within	F 281		5/25/12

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F 281	Continued From page 19 twenty-four (24) hours of admission irregardless of when the resident was admitted. She explained fall interventions were individualized as to what needed to be done to prevent falls or injury and when residents were identified as a fall risk there should be fall prevention interventions put in place.	F 281		5/25/12
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, and family, resident and staff interviews the facility failed to provide the adaptive equipment and assistance needed with meals for a resident to remain as independent as possible for one (1) of five (5) residents observed for activities of daily living. (Resident #47) The findings are: Resident #47 was admitted to the facility with the diagnoses of diabetes mellitus, end stage renal disease and legal blindness. Review of Resident #47's admission Minimum Data Set (MDS) dated 4/12/12 revealed she had mild cognitive impairment and needed limited assistance of one person with eating. Further review of the MDS revealed Resident #47 had highly impaired vision. Review of Resident #47's CNA Care Record Form dated 4/10/12 which nursing assistants use to know how to care for residents revealed the	F 311	F311 Resident # 47 does have an adaptive spoon and assistance with meals. All Residents with physician orders for adaptive feeding equipment will have the feeding equipment provided and assistance as needed with meals. A 100% medical record audit was performed on May 18, 2012 to ensure all Residents have been identified.100 % of all Nursing staff and Dietary staff will be in-serviced by May 17, 2012	5/25/12

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F 311	Continued From page 20 block reading blind was not checked. Review of Resident #47's care plan dated 4/19/12 revealed she had a potential for alteration in nutrition related to poor intake. The goal was that she would consume adequate nutrition and hydration. There were no interventions related to her blindness and her inability to see her food. She also had a self care deficit with activities of daily living and needed assistance with eating, bathing, dressing and grooming. A goal was the resident would increase her independency with the assist of Occupational Therapy. No interventions were in place related to her blindness or the help she would need with eating. An observation was made on 4/26/12 at 12:48 PM of Resident #47 sitting in her room. The resident was sitting up in her wheel chair with her food tray in front of her. She had several different bowls of food that were untouched and a plate of cut up meat that had been pushed off of the plate. An interview was conducted on 4/25/12 at 6:21 PM with Resident #47's family. The family member reported the staff did not feed the resident when they brought her food tray. The family member reported the resident was blind and was unable to navigate all of the different bowls in which the food was served in. The family member stated the resident had never been given adaptive equipment to help her navigate her meal. An interview was conducted on 4/26/12 at 12:48 PM with the Resident #47. She stated the problem was not the food but the way it was	F 311	on providing adaptive feeding equipment with meals and assistance as needed with eating. Staff not able to attend was in-serviced via telephone by May 21, 2012.Monitoring of the equipment used for feeding and the assistance with feeding will occur by Unit Managers , Weekend Supervisor and Dietary Manager daily for two (2) weeks and then weekly for two (2) weeks and then monthly for two (2) months. Results of the monitoring with tracking and trending of the results will be reported to the Performance	5/25/12

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F 311	Continued From page 21 served. She stated when there were four (4) or five (5) little bowls it was hard to know what you are eating. She further stated staff came into the room, uncovered the food and then left. She stated they wonder why I don't eat. An interview was conducted on 4/26/12 at 12:57 PM with Nursing Assistant (NA) #7 who has worked with Resident #47 on day shift this week. She stated she brought in Resident #47's food tray and spoke to the resident. She said we try to get her to do as much as she can for herself but she gets frustrated and won't eat. NA #3 stated she did not know Resident #47 was blind. An interview was conducted on 4/26/12 at 1:10 PM with the Occupational Therapist. He reported he had not worked with Resident #47. He stated for a blind resident a system should be put in place to help them know of their surroundings. Blind residents should have adaptive equipment to help them be aware of what foods are where on their plates. An interview was conducted on 4/26/12 at 5:03 PM with NA #7 who has taken care of resident #47 this week. She stated the CNA Care Record Form is kept in the each resident's room inside their closet door it tells staff what needs to be done for each resident. She reported that she should have known of Resident #47 blindness from report given by the nurses on the hall but she had not been told. An interview was on 4/26/12 at 5:07 PM conducted with Licensed Nurse #6 who filled out and signed the CNA Care Record Form for Resident #47. He stated he was not aware of the	F 311	Improvement Committee by Unit Managers and Dietary Manager for suggestions and recommendations monthly for three (3) months.	5/25/12

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F 311	Continued From page 22 extent of Resident #47's blindness. An interview was conducted on 4/27/12 at 3:22 PM with the Director of Health Services. She stated the information regarding Resident #47's blindness should have been put on her Care Card and this information should have been passed on in report to the appropriate staff. She stated that referrals for therapies should have been generated at care plan conferences that occur two (2) to three (3) days after residents are admitted. She gave no explanation why this had not occurred for Resident #47.	F 311		5/25/12
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 by: Based on observations, and resident and staff interviews the facility failed to provide mouth care for two (2) of five (5) residents observed for mouth care. (Residents #54 and #68) The findings are: Review of the facility's policy entitled Oral Hygiene, dated 4/2012, read in part: "Having a clean, fresh mouth is part of the dignity to which each patient/resident is entitled. Oral hygiene is part of daily care of every patient/resident and includes care of the mouth, teeth, gums, and	F 312	F312 Resident #54 and #68 have and will continue to receive oral care. All Resident will receive oral care daily per facility policy. 100% of all nursing staff will be in-serviced by May 17, 2012 on providing oral care. Staff not able to attend was In-serviced via telephone May 21, 2012. Monitoring of the delivery of	5/25/12

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F 312	Continued From page 23 tongue. The purpose of oral hygiene is to keep these body parts healthy. A mouth in poor condition is uncomfortable and can cause loss of appetite as well as decreased fluid intake. Other parts of the body are often affected by infection and disease of the mouth." 1. Resident #54 was admitted to the facility with the diagnoses congestive heart failure, hypertension and dementia. Review of her most recent Minimum Data Set (MDS) dated 1/26/12, revealed she had moderate cognitive impairment. The MDS further assessed Resident #54 as needing extensive assistance with personal hygiene and bathing. Review of Resident #54's care plan dated 4/16/12 revealed she required extensive assistance with activities of daily living related to her cognitive and functional decline, specifically with toileting, bathing and grooming. An observation was made on 4/25/12 at 8:45 AM of Resident #54 in bed eating her breakfast. Resident was observed to have food debris in her bottom teeth. An observation was made on 4/25/12 at 9:15 AM of Resident #54 up in her merry walker in the hall. She was dressed but continued to have a large amount of food debris in her bottom teeth. An observation was made on 4/26/12 at 9:00 AM of Resident #54 up in the hall in her merry walker dressed. She continued to have food debris in her front bottom teeth. An interview was conducted on 4/25/12 at 9:15	F 312	oral care will occur by Unit Mangers, Case Mix Director, Senior Care Plan Partner, Case Mix Director and Weekend Supervisor. daily for two (2) weeks, bi weekly for one (1) and then monthly for two (2) months. The results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Senior Care Partner (RN Liaison for residents and families) for suggestions and recommendations monthly for three (3) months.	5/25/12

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F 312	Continued From page 24 AM with Resident #54. She reported she had just received her morning care. She stated they changed her brief, dressed her and combed her hair. She stated they did not brush her teeth. An interview was conducted on 4/25/12 at 9:21 AM with NA#1. She reported she did not do mouth care for Resident #54 this morning. She reported she did not provide mouth care because the resident did not have a toothbrush. An interview was conducted on 4/26/12 at 9:00 AM with Resident #54. She stated she has not had her teeth brushed today. An interview was conducted on 4/26/12 at 11:03 AM with the Unit Nurse Manager #1. She stated that mouth care is part of routine morning care. She further stated it was her expectation that staff should brush Resident #54's teeth or set it up for her to brush her own if she is able. An interview was conducted on 4/27/12 at 2:37 PM with the Director of Health Services. She stated that it is her expectation that mouth care be provided at least daily but if they could provide it morning and evening that would be better. 2. Resident #68 was admitted to the facility with the diagnoses of congestive heart failure, hyperlipidemia and dementia. Review of Resident #68's most recent Minimum Data Set (MDS) dated 3/27/12 revealed she had moderate cognitive impairment. The MDS further assessed Resident #68 as requiring extensive assistance with personal hygiene. Review of Resident #68's care plan dated 3/27/12	F 312		5/25/12

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F 312	Continued From page 25 revealed she had a self care deficit for activities of daily living and needed extensive assistance with bathing, dressing and grooming. Interventions included provide personal hygiene daily. An observation was made on 4/26/12 at 12:12 PM of Resident #68 lying in her bed. She was observed to have dark debris in her upper teeth. An observation was made on 4/27/12 at 8:30 AM of Resident #68 in her bed. She continued to have dark debris in her teeth. An interview was conducted on 4/23/12 at 2:38 PM with Resident #68. She reported that staff does not assist her to brush her teeth nor have they ever provided mouth care. An interview was conducted on 4/26/12 at 12:12 PM with Resident #68. She stated staff did not brush her teeth last night or this morning. An interview was conducted on 4/27/12 at 8:30 AM with Resident #68. She stated that her teeth have not been brushed this morning or last night. An interview was conducted on 4/27/12 at 10:04 AM with NA #2. She reported she had been caring for Resident #68 this week on first shift. She reported she had not provided mouth care but that mouth care should be done routinely. She was did not give an explanation of why mouth care had not been provided. An interview was conducted with the Unit Nurse Manager #1 on 4/27/12 at 10:10 AM. She stated mouth care should be provided at least twice per	F 312		5/25/12

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F 312	Continued From page 26 day, in the morning and before going to bed. She stated staff should have brushed her teeth. An interview was conducted on 4/27/12 at 2:37 PM with the Director of Health Services. She stated that it is her expectation that mouth care be provided at least daily but if they could provide it morning and evening that would be better.	F 312		5/25/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and family interviews, the facility failed to implement interventions after exit seeking behaviors to prevent elopement for one (1) of one (1) sampled residents. Resident #91. The findings are: Resident #91 was admitted to the facility on 8/24/10 with diagnoses including cerebral ischemia, muscle weakness, difficulty walking, mental disorder, atrial fibrillation, and dementia. The significant change Minimum Data Set (MDS) dated 11/4/11 and the quarterly MDS dated 1/23/12 coded Resident #91 with moderately	F 323	F323 Resident #91 has a wanderguard that was put in place on May 14 , 2012 related to exit seeking behaviors. All Residents with exit seeking behaviors will have interventions in place as indicated and per physician orders. 100% of all licensed and non licensed nursing staff were in-serviced by May 17, 2012. Staff not able to attend were in-serviced via telephone by May 21, 2012.Monitoring will	5/25/12

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F 323	Continued From page 27 impaired cognitive skills, no behaviors, requiring limited assistance with transfers, bed mobility, and ambulation. The Care Area Assessment dated 11/8/11 for cognition indicated she had periods of confusion and poor safety awareness. On the Elopement Risk Assessment Form dated 1/6/12, Resident #91 scored a six (6) with a score of eighteen (18) or above indicating interventions should be promptly put into place. The narrative note on this assessment stated the resident was alert and oriented. Nursing notes dated 2/26/12 at 11:40 AM stated a visitor came to the nurse, stating that Resident #91 was observed walking outside in front of the building. This note stated the nurse brought her back inside. The resident stated "I am just going no where." Another nursing note dated 2/26/12 stated that at 4:30 PM, Resident #91 was found at the front door of the facility and staff was able to bring her back to her room without incident. The nurse who wrote this note was called but did not return phone calls. On 4/26/12 at 9:44 AM, Nurse Aide (NA) #4 was interviewed via phone. She stated she was on duty and recalled the incident of 2/26/12. NA #4 reported Resident #91 was very restless that day. She stated Resident #91 was either waiting for family or had been out with family and she was walking the halls. NA #4 stated at that time, Resident #91 was not considered an elopement risk. After Resident #91 was returned from the parking lot there was a big discussion as to what	F 323	occur by Unit Managers and Weekend Supervisor weekly for four (4) weeks then bi weekly for one (1) month and then monthly for one (1) month. The results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Director of Health Services for suggestions and recommendations monthly for three (3) months.	5/25/12

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F 323	Continued From page 28 to do. NA #4 stated the nurse wanted to put a wandergard in place but the daughter had previously said no to a wandergard, so no wandergard was implemented. Per NA #4 staff were informed to keep their eye on Resident #91 but there were no definitive times to check on resident #91's whereabouts. On 4/26/12 at 11:44 AM the Administrator stated there was no incident report for the event on 2/26/12. The Administrator stated her internal investigation revealed the weekend receptionist saw her leave the front door of the building and got assistance to redirect her back in the building. After that incident, staff calmed Resident #91 down with one to one supervision until the family came and took her out to lunch. The Administrator stated there were no changes implemented for supervising Resident #91 when she returned from going to lunch with her family. On 4/26/12 at 12:11 PM the weekend receptionist was interviewed in person. The receptionist stated she saw Resident #91 go outside. The receptionist stated she was half watching her when she noticed her walking down the driveway. The receptionist sent the visitor who was in the lobby to get assistance as she kept an eye on Resident #91. Staff then came and redirected Resident #91 inside. Resident #91 had walked to the flag pole at the end of the building when the nurse redirected her back inside. The receptionist stated she left the facility at 4:00 PM and did not see Resident #91 at the front doors again. Nursing notes dated 2/28/12 (no time) stated Resident #91 was found at the end of the driveway by a resident's family. Resident #91	F 323		5/25/12

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F 323	Continued From page 29	F 323		5/25/12

stated she was going to her sister's home. A wandergard was applied to her leg and she was placed on 15 minute checks.

Review of the incident report revealed the evident occurred on 2/28/12 at 7:15 PM. Per the incident report, Resident #91 was found "off the premises". The narrative stated Resident #91 was found at end of driveway of building by another resident's family. The 24 hour follow up note revealed a wandergard was placed on Resident #91.

Physician telephone orders dated 2/28/12 included to check resident every 15 minutes when awake and every 30 minutes when asleep (written on computer 5 minutes) throughout the night and wandergard placed on resident with checks to placement and function every shift.

On 4/25/12 at 6:08 PM Licensed Nurse (LN) #11, who wrote the incident report of 2/28/12 stated the the family of resident #91's roommate brought her back inside and that no one knew she was gone. Resident #91 stated at that time we was going home. Per LN #11, Resident #91 was seen just five minutes before the visitor brought her back inside. The visitor stated she was halfway down the driveway going towards the road. At that time, a wandergard was placed on Resident #91 and she was also placed on 15 minute checks. LN #11 was unaware of the previous attempt on 2/26/12 to leave the premises.

On 4/26/12 at 11:44 AM interview with the Administrator and Director of Health Services revealed elopement assessments are completed quarterly. The Administrator stated that she was

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F 323	Continued From page 30 aware of the first incident on 2/26/12 but was not aware of Resident #91 being found at the front door later that same day. The Administrator stated if she had been told of the housekeeper's finding her at the front door, she would have called the family, but not have done more than encourage activities. Since the incident on 2/28/12, the Administrator stated they have begun to discuss placement on the secured unit for Resident #91. On 4/25/12 at 9:46 AM, on 4/25/12 at 12:40 PM, on 4/25/12 at 4:25 PM, and on 4/26/12 at 11:38 AM Resident #91 was observed walking independently.	F 323		5/25/12
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	F329 Resident #5 has had his Prothrombin Time/International Normalized Ratio (PT/INR) blood level drawn February 13, 2012 and February 17, 2012 with results reported to the Physician on February 17, 2012. All Residents that require PT/INR blood results will have the test	5/25/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 31 drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to draw an ordered Prothrombin Time/International Normalized Ratio (PT/INR) for one (1) of four (4) residents receiving Coumadin. (Resident #5) The findings are: A review of Resident #5's medical record revealed he was admitted to the facility with diagnoses which included hypertension, diabetes mellitus, and atrial fibrillation. Further review of Resident #5's medical record revealed a physician's order dated 2/13/12 for Coumadin to be held 2/13/12 then Coumadin 3 milligrams (mg) on 2/14/12 and recheck PT/INR on 2/15/12. Review of Resident #5's Medication Administration Record (MAR) revealed Coumadin 3 mg. was given on 2/14/12. Also written on the MAR was PT-INR to be drawn on 2/15/12 which was not initialed by the nurse as being completed. Review of nurse's notes dated 2/17/12 revealed the PT-INR due on 2/15/12 was not done but a PT-INR was drawn and sent to the lab on 2/17/12.	F 329	drawn as ordered by the physician to be performed seven (7) days a week. 100% of all Licensed Nurses was in-serviced on May 17, 2012. Staff not able to attend were in-serviced via telephone by May 21,2012. The lab results will be reviewed in the morning clinical meeting which takes place Monday thru Fridays to ensure PT/INR labs have been drawn as ordered. Members of the morning clinical meetings include The Director of Health Services, Unit Managers, Senior Care Partner, Case Mix Director and treatment nurses. Monitoring of the PT/INR lab draws will occur by Unit Managers and Weekend Supervisor	5/25/12

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F 329	Continued From page 32 Review of laboratory result for PT-INR dated 2/17/12 revealed PT results were 68.1 seconds and INR result of 6.7 (normal values 0.9 - 4.0). The elevated laboratory results were called to the attending physician by laboratory personnel. A physician's order dated 2/17/12 read "Hold Coumadin for two (2) days, 2/17/12 and 2/18/12. Give Coumadin 2 mg. on 02/19/12; recheck PT-INR on 02/20/12. Monitor signs and symptoms of bleeding bruising." An interview was conducted on 4/27/12 at 8:43 AM with Unit Nurse Manager #1 regarding the system for labs and Coumadin. She reported the nurse takes the order for the next lab (PT-INR) and the new Coumadin dose. The order and the next lab are written on the MAR and on the Coumadin Flow Sheet, which is kept in the MAR. The order for the next lab is put in the Lab Book. These lab slips are kept for one month and then discarded. She further reported the morning nurse should have noticed the lab was to be done by the Coumadin Flow sheet in the MAR and by the lab slip in the Lab Book. She reported she did not know why the lab was missed as it was written on the MAR and on the Coumadin Flow Sheet. She stated she was unaware a PT-INR had been missed for Resident #5. An interview was conducted on 4/27/12 at 12:29 PM with the Director of Health Services (DHS). She stated the lab result for Resident #5's PT-INR was high. She reported she did not know what happened and was unaware the situation had occurred. She stated the lab should have been drawn per the physician's order.	F 329	daily for two (2) weeks, then biweekly for one (1) month with continued monitoring for two (2) months. The results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Director of Health Services for suggestions and recommendations monthly for three (3) months.	5/25/12
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334		

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F 334 SS=D	Continued From page 33 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: (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	F 334	F 334 Resident #82 did receive the pneumococcal vaccine on May 21,2012. All Residents that request the pneumococcal vaccine will receive the vaccine within the appropriate guidelines of the Centers for Disease Control (CDC) of administration or unless contraindicated by the physician. 100 % all licensed nurses will be in-serviced on May 17, 2012. Staff not able to attend were in-serviced via telephone by May 21, 2012. A 100 % chart audit will be performed to ensure all Residents have received the vaccine as requested by May 21, 2012.	5/25/12

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F 334	Continued From page 34 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 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 staff and family interviews and record reviews the facility failed to administer the Pneumococcal Vaccine to one (1) of nine (9) residents after the family signed the consent form that requested it be given. (Resident #82). The findings are: The facility policy for Pneumococcal Vaccinations	F 334	New admissions will be reviewed in the twenty four (24) hour meetings to ensure they have received the vaccine as requested. Director of Nursing Services, Unit Managers, Social Service, Case Mix Director, Senior Care Partner and treatment nurses are in attendance during the twenty four (24) hour meeting. Twenty four hour meetings are held Monday thru Friday daily. The monitoring of the results of the audit and the administration of the pneumococcal vaccine will occur by Unit Managers and Weekend Supervisor's bi weekly for one (1) month and then monthly for two (2) months.	5/25/12

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F 334	Continued From page 35 dated: Revised:12/11; stated, "All patients/residents who reside in this healthcare center are to receive the pneumococcal vaccine within the current CDC (Center for Disease Control) guidelines unless contraindicated by their physician or refused by the patient/resident's family." Resident #82 was readmitted to the facility on 2/17/2010 with diagnoses including atrial fibrillation and hypertension. Review of the Immunization record in Resident # 82's chart revealed no documentation under the section for Pneumonia Vaccination. Further review of the chart revealed a consent form was signed dated 9/2/11 giving permission for the Pneumococcal Vaccine to be administered. Interview on 4/24/2012 at 10:00 AM with Licensed Nurse #1 (LN #1) confirmed the Pneumococcal Vaccine permission form on the chart had been signed 9/2/2011 and the Immunization form had no documentation that the Pneumococcal Vaccine had been administered. LN #1 confirmed she had searched the current chart and thinned records and was unable to locate any documentation that the consent form had been followed through by having obtained the Physician's order or administered the Pneumococcal Vaccine. Interview on 4/24/2012 at 10:30 AM with Resident #82's family member confirmed they had expected Resident #82 to have been given the Pneumococcal Vaccine after the consent had been signed and still wanted her to have it. Interview on 4/26/2012 at 5:00 PM with the	F 334	The results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Unit Managers for recommendations and suggestions monthly for three (3) months.	5/25/12

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F 334	Continued From page 36 Director of Health Services (DHS) and responsible for Infection Control revealed the facility immunization forms are a work in progress. She confirmed she expected the Immunization Record to contain current information and the Vaccine Permission forms to have been followed through.	F 334		5/25/12
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family interview and staff interview, the facility failed to provide meat in a chopped consistency as ordered for two (2) of three (3) sampled residents. (Residents #18 and # 91). The findings were: 1. Resident #91 was admitted to the facility on 8/24/10 with diagnoses including cerebral ischemia, muscle weakness, difficulty walking, mental disorder, atrial fibrillation and dementia. The significant change Minimum Data Set (MDS) dated 11/4/11 and the quarterly MDS dated 1/23/12 coded Resident #91 with moderately impaired cognitive skills, required supervision to eat and received a therapeutic diet. The quarterly MDS dated 4/16/12 coded her with severe cognitive impairment and needing limited assistance to eat.	F 365	F365 Resident #18 and #19 have and will continue to have their meals at the proper consistency as ordered by the physician. All Residents who have their meals with foods at the chopped consistency have the potential to be affected by the same cited deficient practice and will be identified by a 100% audit of the (meal tray card / physician orders by May 21, 2012. A 100% In-service of the Dietary staff and 100% of all nursing staff will occur	5/25/12

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F 365	Continued From page 37 The monthly computerized physician orders for April 2012 revealed Resident #91 was to receive a regular no added salt diet. On 4/23/12 at 3:30 PM Resident #91's family stated they had been asking for Resident #91 to be evaluated for chopped meat because she was unable to cut her meat up and would leave the table without eating. ON 4/25/12 at 12:24 PM Resident #91 was observed being evaluated at the noon meal by Speech Therapy (ST). On 4/25/12 at 5:58 PM Resident #91 did not eat any of her roast beef sandwich. She had received a roast beef sandwich which consisted of three slices of roast beef and a slice of cheese between two pieces of bread. The tray card had been changed by hand to reflect "chopped meat, NAS". On 4/26/12 at 9:34 AM interview with ST revealed she evaluated Resident #91 because family had requested she have chopped meat. ST stated that Resident #91 was unable to cut up her own meat at the evaluation. ST stated she obtained an order for chopped meat at around 3:00 PM on 4/25/12. On 4/26/12 at 5:27 PM Resident #91's supper meal tray was sent out from kitchen and contained a full chicken patty on a bun. The staff delivering the tray, did not serve it and requested ground chicken. The tray card was reviewed and noted the diet printed on the card was for a Regular, NAS diet. Staff who caught the regular	F 365	by May 17, 2012 on how to properly chop foods. Staff not able to attend was in-serviced via telephone by May 21, 2012. Monitoring of the chopped foods for meals will occur by Dietary daily for two (2) weeks then weekly for two (2) weeks. Monitoring will continue bi weekly for two (2) months. Results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Dietary Manager for suggestions anc recommendations monthly for three (3) months.	5/25/12

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F 365	Continued From page 38	F 365		5/25/12

chicken patty stated the kitchen often sent out the incorrect form of food.

On 4/27/12 at 7:55 AM Resident #91 left her plate with a sausage patty cut up in large chunks. One piece of sausage was approximately two inches long.

On 4/27/12 at 8:00 AM the Dietary Manager (DM) stated diets are changed as soon as a communication slip came to the kitchen. The DM observed the sausage piece and stated the sausage at the morning meal was ok as it was easily cut up with a fork. The DM stated Resident #91 was on the select dining which meant she was able to choose her meals. When asked about Resident #91's chopped meat order, the DM stated that residents on the select dining got what they wanted and the kitchen did not follow the physician ordered consistency of food. At 8:10 AM on 4/27/12, the DM stated this was incorrect and she would educate her staff.

2. Resident #18 was admitted to the facility on 1/6/12 with diagnoses including late effective intracranial injury and muscle weakness.

On 1/17/12 a lipped plate and bent left handed spoon was implemented by occupational therapy due to tremors.

The admission Minimum Data Set (MDS) dated 1/18/12 coded Resident #18 as having intact cognition and requiring set up and supervision for eating.

On 2/5/12 a physician's telephone order added chopped meats to the regular no added salt, no

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F 365	Continued From page 39 concentrated sweets diet. On 4/2512 at 12:50 PM, Resident #18 received chopped turkey. There was a large two inch by two inch piece of turkey served to him. On 4/25/12 at 1:10 PM interview with the Dietary Manger revealed if meats like turkey are soft, then the meat is chopped by hand. If the meats are tough then a food processor is used. The turkey was hand chopped today. She was unable to visualize Resident #18's slice of turkey.	F 365		5/25/12
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and staff interviews, the facility failed to provide an adaptive spoon to one (1) of one (1) sampled residents. Resident #18. The findings are: Resident #18 was admitted to the facility on 1/6/12 with diagnoses including late effective intracranial injury and muscle weakness. Review of Occupational therapy (OT) notes dated 1/13/12 revealed Resident #18 was assessed for using weighted utensils. OT notes dated 1/17/12 stated Resident #18 was seen for self feeding. A weighted spoon was tried with less spillage noted. Then a bendable spoon for left hand was tried	F 369	F 369 Resident #18 does have the adaptive spoon as ordered. A 100 % medical record audit of physician orders/ tray cards will be performed by May 21, 2012 to identify all Residents needing adaptive eating equipment. A 100% non nursing and licensed nursing staff will be in-serviced on how to process recommendations by the Speech Therapist. This in-service will be	5/25/12

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F 369	Continued From page 40 with greater success. This note indicated a communication was sent to the dietary department for a lipped plate and bendable spoon for all meals. This communication form was dated 1/17/12. The admission Minimum Data Set (MDS) dated 1/18/12 coded Resident #18 as having intact cognition and requiring set up and supervision for eating. The Care Area Assessment dated 1/24/12 assessed Resident #18 as feeding himself and receiving therapy services. The quarterly MDS dated 4/16/12 coded him as requiring limited assistance with meals. Review of the care plans originally developed 1/18/12 and last updated 4/17/12 for activities of daily living skills and for nutrition did not have any interventions related to eating equipment. On 4/25/12 at 8:16 AM, Resident #18 was observed feeding himself breakfast at the side of his bed. The tray card indicated the use of a blue (lip) plate and a left handed bent spoon. Resident #18 was observed feeding himself with his left hand but there was not left handed bent spoon on the tray. At this time he stated he was not left handed by choice, that he had tremors in his right hand and had to use his left hand to eat. He further stated yesterday was first time in a long time a left handed bent fork was provided to him. He further stated he needed the left handed bent spoon for things like mixed veggies and items hard to keep on a regular fork.	F 369	given by the Director of Health Services on May 17 ,2012.Also on May 17, 2012, 100% of dietary staff will be in-serviced on tray line delivery of adaptive equipment by the Food Service Manager. Staff not able to Attend were in-serviced via telephone By May 21, 2012. Monitoring of the delivery of adaptive eating equipment to the meal tray will occur by Unit Managers and Dietary Manager daily for two (2) weeks then bi-weekly for a total of one (1) month and then bi-weekly for two (2) months.	5/25/12

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F 369	Continued From page 41 Resident #18 did not receive a left handed bent spoon on 4/25/12 at 12:50 PM for the noon meal. On 4/25/12 at 6:00 PM Resident #18 stated he did not receive his bent spoon for this day's evening meal. He further stated it would help at times. On 4/26/12 at 12:48 PM Resident #18 received his tray which did not included a left handed bent spoon. Nurse Aide #5 and NA #3 stated Resident #18 was provided a bent spoon when he needed it but he did not always need it. NA #5 stated Resident #18 used to refuse the spoon. Together NA#5 and the surveyor went to Resident #18 and NA #5 asked Resident #18 to explain why he did not use the bent spoon anymore. Resident #18 stated he hadn't received one on his try for some time. On 4/26/12 at 6:00 PM The Rehabilitation Director stated that Occupational Therapy assessed Resident #18 and put in a communication to the dietary department for the left handed bent spoon. Further discussion revealed Resident #18 sometimes preferred to use a large soup spoon, especially for his cereal, however, a left handed bent spoon was issued to him and he should receive it at every meal. On 4/26/12 at 4:27 PM The Dietary Manager stated the girls on the tray line were responsible for ensuring Resident #18's bent spoon was included on his tray. The tray line server was interviewed on 4/26/12 at 4:36 PM and stated Resident #18 had a left handed bent spoon which should be on his tray at every meal. When asked about him not getting the spoon for the observations made this week, she offered no	F 369	Results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee By the Dietary Manager for recommendations and suggestions monthly for three (3) months.	5/25/12

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

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F 369	Continued From page 42 explanation.	F 369		5/25/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove and dispose of twelve (12) outdated cartons of milk available for use in one (1) of three (3) nourishment rooms. The findings are: During the initial tour of the facility on 4/23/2012 at 10:45 AM an observation of the 500 hall nourishment room revealed a refrigerator with a total of twelve (12) outdated milk cartons. There were five (5) cartons of Lactaid milk dated 4/19/2012, five (5) cartons of regular milk dated 4/21/2012 and two (2) cartons dated 4/17/2012. A further observation revealed a large dried puddle of brown substance in the bottom of the same refrigerator. Interview on 4/23/2012 at 10:50 AM with Licensed Nurse #3 (LN #3) revealed the nourishment room was stocked with items and ready for use for	F 371	F371 There are no named Residents in this citation. All nourishment room refrigerators will have milk removed that is outdate. These were removed April 27, 2012 (last day of survey). A 100% in-service of all housekeeping and non licensed and licensed nursing staff will be held by May 17, 2012 on checking dates of milk in the nourishment refrigerators. Staff not able to attend was in-serviced via telephone by May 21, 2012. Monitoring of the dates of the milk in the nourishment refrigerators	5/25/12

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F 371	Continued From page 43 patients. She stated she thought housekeeping staff was responsible for cleaning out the refrigerator and discarding items that were out of date. Interview on 4/23/2012 at 11:05 AM with Housekeeper #1 revealed she had no knowledge of housekeeping being responsible for cleaning out the refrigerators and discarding outdated items. Interview on 4/24/2012 at 8:30 AM with the Dietary Manager revealed the Dietary staff only supplied the nourishment refrigerators and that housekeeping was responsible to clean them and remove expired items. Interview on 4/24/2012 at 3:45 PM with the Director of Housekeeping and Laundry revealed the responsibility to clean the nourishment refrigerators and discard the expired items was given to his department on 4/24/2012 due to the Dietary staff who had been assigned was out on leave since sometime last week. He confirmed the Dietary staff member that had been assigned that duty in the past would check the refrigerators regularly for expired items and would let him know if the refrigerators needed cleaning.	F 371	will be done by Director of Housekeeping and Dietary Manager. Monitoring will continue to occur bi-weekly for the next two (2) months. Results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee by Dietary Manger for recommendations and suggestions monthly for three (3) months.	5/25/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F431 There are no named residents in this citation. A 100 % medication cart, medication room	5/25/12

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F 431	Continued From page 44 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to date a medication when opened and discard expired medications in one (1) of three (3) medication refrigerators and three (3) of six (6) medication carts. The findings are: 1. Review of the facility policy for "Medication	F 431	and medication refrigerator audit will occur by May 21, 2012 to ensure all out of date medications have been removed and open medication has been dated as required by the manufacturer. 100% of all licensed nurses will be in-serviced by the Director of Health Services on dating medication as required and disposing of out of date and expired medications. Staff not able to attend was in-serviced via telephone by May 21, 2012.	5/25/12

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F 431	Continued From page 45 Storage in the Healthcare Centers" dated Revised: 12/11 states under #11: "Multi-dose containers of injectables, ophthalmic and otic preparations and inhalers are to be dated and initialed when opened. Except where manufacturer recommendations require shorter expiration date, the above items shall be discarded after 90 days." Observation of the West Wing refrigerator on 4/27/2012 at 11:15 AM revealed two opened partially used vials of Tuberculin Purified Protein Derivative (PPD). One was dated as opened on 4/2/2012 and the other one was undated. During an interview on 4/27/2012 at 11:17 AM with Licensed Nurse (LN) #2, who was assigned to the West Wing, confirmed the PPD vial was open and undated. LN #2 revealed the facility policy was for vials of PPD to be dated when opened and discarded after 30 days. LN #2 confirmed the undated vial was to be disposed of immediately. Interview on 4/27/2012 at 3:15 PM with the facility Pharmacist revealed the manufacturer's recommendations for PPD were the vials were to be dated when opened and discarded after 30 days of opening. He confirmed he expected the facility staff to follow this and if a vial was found to be undated it was to be thrown away immediately. Interview on 4/27/2012 at 4:00 PM with the Director of Health Services (DHS) revealed she expected the facility policy that concerned dated and discarded multi-dose vials to be followed and agreed with the Pharmacist's recommendations.	F 431	Monitoring of the dates of open medication and disposal of out of date medications will occur by Unit Managers and Weekend Supervisors weekly for four (4) weeks then bi-weekly for two (2) months. Reporting of the results of the monitoring with tracking and trending to the Performance Improvement Committee will be done by Unit Managers for suggestions and recommendations monthly for three (3) months.	5/25/12

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F 431	Continued From page 46	F 431		5/25/12

2. A review of a facility policy titled "Medication Storage in the Healthcare Centers" with a revised date of 12/11 indicated Procedure #3: "Nurses are required to check all medications for deterioration and expiration before administration and Procedure #13: "Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists."

During an observation on 4/27/12 at 10:15 AM of stock medication storage in Medication Cart #1 for the 100,200 and 300 Halls one (1) bottle of Colace 100 soft gels (stool softener) had an expiration date of March 2012.

During an observation on 4/27/12 at 10:20 AM of medication storage in Medication Cart #2 for the 100,200 and 300 Halls one (1) bottle of Colace 100 soft gels had an expiration date of March 2012 and one (1) bottle of Vitamin E- 400 international units (IU) had an expiration date of March 2012.

During an observation on 4/27/12 at 11:45 AM of medication storage in the Medication Cart in the locked unit (MSU) one (1) bottle of Colace 100 soft gels had an expiration date of March 2012 and one (1) bottle of Multi-vitamins had an expiration date of March 2012.

During an interview on 4/27/12 at 11:47 AM with LN #8 she verified the medications in Medication Cart #1 for the 100, 200 and 300 halls had expired dates on the bottles and stated the night

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F 431	Continued From page 47 shift nurses were responsible for checking expiration dates on medications and they should have been discarded. She verified the medications were available for any resident who had an order for that medication. During an interview on 4/27/12 at 11:53 AM with LN #10 she verified the medication in Medication Cart #2 for the 100, 200 and 300 halls had an expired date on the bottle and explained the stock medications stored in the medication carts were for any resident with orders for those medications. She further stated if the medications were in the cart they were available for residents and given when a resident needed it. During an interview on 4/27/12 at 11:58 AM with LN #1 she verified the medications in the Medication Cart in the locked unit had expired. dates on the bottles and stated they should have been discarded. During an interview on 4/27/12 at 12:04 PM LN #9 stated every nurse was responsible for checking medication containers for expired medications before they gave the medication. He further stated the stock medications were for all residents who had an order to the medication and if they were in the medication cart would likely be given to a resident. During an interview on 4/27/12 at 5:21 PM with Unit Nurse Manager #2 she explained all medication storage rooms and medication carts were checked routinely for expired medications and stated that meant at least once weekly by nurses and by a pharmacist once a month. She	F 431		5/25/12

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F 431	Continued From page 48 further stated medications should be discarded immediately if an expiration date was found on the container. During an interview on 4/27/12 at 5:06 PM the Director of Health Services (DHS) stated it was her expectation all nurses should check for expiration dates on medication containers in the medication carts and medication storage rooms before they gave the medication. She stated if they saw an expired date on a medication container they should discard it immediately.	F 431		5/25/12
F 492 SS=B	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit requests for Medicare claim review (demand bills) for two (2) of two (2) sampled residents. The facility also charged two (2) of two (2) sampled residents while their claims were reviewed. (Residents #165 and #171). 1. The Facility Staff (FS #1) responsible for Medicare Provider Notices spoke over the phone on 4/17/2012 with Resident #165's responsible party to inform him that she would be off Medicare as of 4/21/2012. The Responsible Party came to the facility and signed the form on	F 492	F 492 The facility will provide services that will be in compliance regarding Medicare Demand Bills by in-service education provided by the Administrator to the Case Mix Manager and Financial Counselor by May 21, 2012. Demand bills for resident # 165 and #171 was submitted on 4/21/2012 to Center for Medicare and Medicaid Services. Case Mix Manager will review Notice of	5/25/12

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	345462	A. BUILDING ______ B. WING ______	C 04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 492	Continued From page 49 4/18/2012 and chose Option 1 on the form indicating that he wanted Resident #165 to receive the skilled services and that he would be notified when the Medicare claim was submitted. Option 1 also indicated that Resident #165 would not be billed until Medicare made its decision whether Medicare would pay for the requested skilled services. Interview with the FS#1 on 4/27/2012 at 4:30 PM revealed she did not understand that by picking Option 1, the facility agreed to submit a demand bill to Medicare and she verified no demand bill claim process had been initiated. She stated she did not think the family member understood the process either and by circling Option 1 was saying he felt the facility was doing a good job. Interview on 4/27/2012 at 4:30 PM with the Corporation Representative Clinical Nurse and Financial Counselor, also present during the interview with FS#1, confirmed they also did not know this Option 1 meant to bill so the facility had failed to bill the resident. 2. The Facility Staff (FS #1) responsible for Medicare Provider Notices spoke over the phone on 4/25/2012 with Resident #171's responsible party to inform her that he would be off Medicare as of 4/29/2012. The Responsible Party came to the facility and signed the form on 4/25/2012 and chose Option 1 on the form indicating that she wanted Resident #171 to receive the skilled services and that she would be notified when the Medicare claim was submitted. Option 1 also indicated that Resident #171 would not be billed until Medicare made its decision whether Medicare would pay for the requested skilled	F 492	Medicare Provider Non- Coverage benefits for Part A with resident/and or responsible party within five (5) days prior to last coverage day. An audit to ensure compliance will be performed by Financial Counselor and/or Case Mix Manager will be performed monthly X 3.Reporting of the results of monitoring will be reported to the Performance Improvement Committee by the Financial Counselor for suggestions and recommendations monthly for three (3) months.	5/25/12

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

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F 492	Continued From page 50 services. Interview with the FS#1 on 4/27/2012 at 4:30 PM revealed she did not understand that by picking Option 1, the facility agreed to submit a demand bill to Medicare and she verified no demand bill claim process had been initiated. She stated she did not think the family member understood the process either and by circling Option 1 was saying she felt the facility was doing a good job. Interview on 4/27/2012 at 4:30 PM with the Corporation Representative Clinical Nurse and Financial Counselor, also present during the interview with FS#1 confirmed they also did not know this Option 1 meant to bill so the facility had failed to bill the resident.	F 492		5/25/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 514	F 514 Resident #170 no longer resides at the facility. All new admissions and readmission will have complete documents in the medical record to include nursing assessments and other assessments as clinically indicated and an initial plan of care.	5/25/12

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F 514	Continued From page 51 record reviews facility staff failed to complete documents for the medical record on admission to the facility for an initial nursing assessment, a fall risk assessment and care plan for one (1) of four (4) sampled residents. (Resident #170). The findings are: A review of a facility document titled "Admission Assessments" with a revised date of 4/03 indicated under Policy: "The licensed nurse will complete the Admission/Nursing Evaluation Form on admission. The Comprehensive care Plan will be based in part on this assessment." A review of a facility document titled "Fall Risk Assessment" with a revised date of 2/10 indicated under "Guideline: All patients/residents will be assessed on admission, re-admission, significant change in condition, and at least quarterly. Patients/residents who score (10) or more, interventions should be promptly put in place." Resident #170 was admitted on 4/6/12 at 2:39 PM with diagnoses including a urinary tract infection, generalized muscle weakness, osteoporosis, high blood pressure, asthma, anxiety and depression. Resident #170 was transferred to the hospital on 4/9/12 due to increased confusion and a fall from a wheelchair with moderate right (R) foot pain. A review of a "Hospital Report Form" dated 4/6/12 indicated "Does the patient/resident have a Fall Risk (Complete Fall Risk Assessment)" and an "x" was marked next to "yes." A review of an "Admission/Nursing Evaluation	F 514	100% of all licensed nursing staff will be inserviced by the Director of Health Services on completion of the admission and re-admission assessments and plan of care. Staff not able to attend was in-serviced via telephone by May 12, 2012. A twenty four (24) hour chart audit will occur on all new admissions and readmissions using the initial admission and fall assessment monitoring tool to ensure proper compliance. Monitoring of the results of the twenty four (24) hour audit will occur by the Unit Managers and Weekend Supervisor-- weekly for two (2) weeks bi-weekly for	5/25/12

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F 514	Continued From page 52 Form" indicated there were a total of 31 assessment sections and a signature page at the end of the document for staff to sign when they completed sections of the form. The signature page indicated the following sections from 3-31 were completed on 4/9/12 by Licensed Nurse (LN) # 6: Section 3: Level of Consciousness Section 4: Memory Section 5: Sleep Pattern Section 6: Patient/Resident ' s Demeanor Section 7: Communication/Sensory Section 8: Head/Face Section 9: Neck Section 10: Oral Section 11: Neurological Section 12: Mobility/Ambulation/Musculoskeletal Section 13: Respiratory/Chest Section 14: Breasts Section 15: Cardiovascular Section 16: Abdomen Section 17: Toileting Section 18: Bladder Section 19: Bowel Section 20: Foot Assessment Section 21: Dressing/Grooming/ADL Section 22: Transferring Section 23: Eating Section 24: Hydration Section 25: Medication Review Section 28: Special Need Section 29: MD names Section 30: Interim Care Plan Section 31: Other Information The Admission/Nursing Evaluation Form further indicated Section 26 titled "Body Audit" and Section 27 "Braden Scale For Predicting	F 514	two (2) weeks and then monthly for two (2) months. Results of the monitoring with tracking and trending will be reported to the Performance Improvement Committee By the Unit Managers for recommendations and suggestions monthly for three (3) months.	5/25/12

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F 514	Continued From page 53 Pressure Sore Risk" was completed by a wound care nurse LN #5 on 4/9/12. A review of Section 30 on the Admission/Nursing Evaluation Form and titled "Interim Care Plan" indicated there was a blank check box next to a statement "Completed and placed under CP (care plan) section of chart." During an interview on 4/25/12 at 5:15 PM with LN # 4 revealed she took care of Resident #170 on Saturday 4/7/12 and Sunday 4/8/12 from 6:00 PM to 6:00 AM and she did not document an initial nursing assessment, a fall risk assessment or care plan because the resident had been admitted during the day on Friday 4/6/12 and she didn't realize they weren't done. During an interview on 4/26/12 at 9:54 AM LN #5 who was also a Wound Care Nurse stated she did not see Resident #170 until Monday 4/9/12 between 3:30 and 4:00 PM and verified she did Section 26 "Body Audit" and Section 27 Braden Scale on the Admission/Nursing Evaluation Form because she was told Resident #170 had a fall from her wheelchair earlier in the day and she went to assess her skin. During an interview on 4/26/12 at 10:28 AM with LN # 2 she verified she completed the Hospital Report Form on 4/6/12 when a nurse at the hospital called and gave information about Resident #170 before she was came to the facility. She further verified she was told the resident was a fall risk and she documented the "x" next to the question "yes" on the form. She explained she took care of Resident #170 on Monday 4/9/12 and assessed her after she fell	F 514		5/25/12

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F 514	Continued From page 54 out of her wheelchair that day. She stated she was not sure why an admission assessment or a fall risk assessment was not done when Resident #170 was admitted. She explained the initial nursing assessment was supposed to be done after the resident was admitted and she always tried to do the body assessment and a nurse's note "right away" but she stated "everyone did it differently." During an interview on 4/26/12 at 10:50 AM with LN #6 he stated he worked on Monday 4/9/12 and reviewed several charts of new admissions as part of his quality assurance (QA) duties and found the initial nursing assessment on the Admission/Nursing Evaluation Form had not been done for Resident #170 so he assessed the resident and completed sections 3-31 on the form. He stated he did not know why it wasn't done after the resident was admitted but it should have been filled out within the first twenty-four (24) hours of admission and the initial skin assessment should have been done within eight (8) hours after admission. LN #6 verified there was no fall risk assessment in Resident #170's chart and there was no documentation on a care plan or other document regarding whether the resident had fall prevention interventions while she was in the facility. During an interview on 4/26/12 at 11:20 AM Unit Manager #1 stated she first saw Resident #170 on Saturday 4/7/12 but she did not realize the initial nursing assessment or fall risk assessment had not been done. The Unit Manager verified the "Hospital Report Form" indicated Resident #170 was a fall risk but there was not a Fall Risk Assessment in her medical record. She stated	F 514		5/25/12

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F 514	Continued From page 55 the Admission/Nursing Evaluation Form, care plans and Fall Risk documents should have been completed and placed in Resident #170's medical record within twenty-four (24) hours after she was admitted to the facility. During an interview on 4/26/12 at 4:46 PM with LN #7 she explained Resident #170 was admitted to the facility on Friday afternoon 4/6/12 and the resident had increased anxiety around 9:30 PM and kept calling for assistance to the bathroom. She verified she did not do an initial nursing assessment or fall risk assessment because Resident #170 was agitated and said she didn't want to be bothered. During an interview on 4/27/12 at 5:06 PM the Director of Health Services (DHS) stated it was her expectation the Admission/Nursing Evaluation Form and The Fall Risk Assessment should be completed within twenty-four (24) hours of admission irregardless of when the resident was admitted during the week or on weekends. She explained fall interventions were individualized as to what needed to be done to prevent falls or injury and when residents were identified as a fall risk there should have been a care plan completed with fall risk interventions identified.	F 514		5/25/12