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
	345433	A. BUILDING ______ B. WING ______	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide privacy for one (1) of three (3) residents observed for care (Resident #39).	F 164	This Plan of Correction (PoC) does not constitute an admission or agreement by Clay County Care Center of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This PoC is prepared solely because it is required by state and Federal law. Plan was revised on July 25, 2012. **F 164 PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS** A.) The action that is being accomplished for Resident #13 is Licensed Nurse (LN) # 6 and LN#7 were re-educated on June 27, 2012 on the correct procedure for observing personal privacy during care. The blind in Resident #39's room was repaired on June 27, 2012. B.) Licensed nurses and Certified Nursing Assistants will be re-educated on the correct procedure for observing personal privacy during care. New employees will be inserviced on the correct procedure for observing personal privacy during care when hired. On July 17th and 18th, 2012 all resident blinds were checked to ensure they work properly. Any blinds that were in need of repair are now functioning. New Employees will also be inserviced on the importance of reporting and how to Continued on page -2-	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA
TITLE: Administrator
(X6) DATE: 7/27/12

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

original signature date 7-23-12 mh

RECEIVED
JUL 30 2012
BY:

PRINTED: 07/13/2012
FORM APPROVED
OMB NO. 0938-0391

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F 164	Continued From page 1 The findings are: Resident #39 was admitted to the facility on 03/13/12 with the diagnosis of dementia. Review of Resident #39's most recent quarterly Minimum Data Set dated 06/11/12 revealed she had severe cognitive impairment and was totally dependent for all activities of daily living. An observation was made on 06/28/12 at 9:23 AM of Resident #39's pressure wound dressing change. The dressing change was performed by Licensed Nurse (LN) #7 and she was assisted by LN #6. During the dressing change, Resident #39 was in her bed, lying on her side facing the door to the room and was in the bed next to the window. LN #7 attempted to close the window blinds. LN #6 and #7 did not close the door to the room nor did they pull the curtain around the bed. The bed curtain was pulled to half the length of the bed. Resident #39's pants were removed as well as her incontinence brief. LN #7 then changed the pressure wound dressing. Resident #39's roommate was not in the room during the dressing change nor was anyone observed in the hallway looking in. The window was large and at a height that if someone was walking by they would be able to see in. The window looked out on a grassy area and no one was observed looking in. An interview was conducted on 06/27/12 at 4:07 PM with LN #7. She stated she should have pulled the curtain and closed the door. She stated she tried to close the blinds but they were broken. LN #7 further stated although Resident #39 bottom was exposed toward the window and not the door her privacy was not protected. She did not offer an explanation of why she did not close	F 164	Continued from page -1- report any malfunctioning equipment such as window blinds. Employees will also be re-educated on the importance of reporting and how to report any malfunctioning equipment such as window blinds. The re-education will be completed by July 26, 2012. C.) The Director of Clinical Services/Unit Manager will ensure resident's personal privacy is observed by conducting audits five times a week. The audits will include observation of staff providing direct care to ensure personal privacy is being provided for all residents. The audits will be for a minimum of one month. With the approval of Quality Assurance Committee (QAC) after one month; the audits will go to one time a week for the next quarter or until the QAC directs otherwise. D.) The Administrator/Director of Clinical Services will review the audits to ensure completion and adequacy. Results of the audits will be reported to the Quality Assurance Committee. Any corrective actions will be implemented as needed. The Medical Director, Administrator, and Director of Clinical Services are responsible for the actions of the QAC. To be completed by July 26, 2012. Continued on page -3-	7/26/12

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F 164	Continued From page 2 the door or pull the curtain. During an interview on 06/27/12 at 4:54 PM LN #6 stated she should have closed the door and pulled the curtain prior to the dressing change. She did not offer an explanation of why she did not close the door or pull the curtain. An interview was conducted on 6/28/12 at 11:12 AM with the Director of Nursing. She stated it was her expectation that the door be closed as well as the curtain pulled around the bed to protect the resident's privacy. She further stated if possible the window blinds should have been closed.	F 164	Continued from page -2-	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and medical record review, the facility failed to correctly adjust a padded foot cradle on a resident's wheelchair, leaving the resident's feet dangling, for one (1) of three (3) residents (Resident #2). The findings are: Resident #2 was admitted to the facility with the diagnoses of profound intellectual disability,	F 246	**F 246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES** A.) The action that is being accomplished for Resident #2 is the padded foot cradle was adjusted on June 28, 2012 by Occupational Therapy Assistant (OTA) and NA#1. B.) An audit was conducted by the Director of Clinical Services and Unit Manager to ensure all residents in wheelchairs will have the correct foot positioning. This audit was completed on July 17, 2012. New residents will be assessed upon admission. Licensed Nurses and Certified Nursing Assistants were educated in proper wheelchair positioning to include positioning of feet. Appropriate adjustments and recommendations will be completed by July 26, 2012. Completed on page -4-	

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aphasia, and seizure disorder. The most recent Minimum Data Set (MDS) dated 05/23/12 revealed the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required total assist with all activities of daily living including positioning and wheelchair ambulation. The MDS further revealed Resident #2 had range of motion impairment in both lower extremities.

The plan of care for Resident #2, dated 05/25/12, addressed the prevention and treatment of contractures. One intervention was attachment of a foot cradle to the specialty wheelchair "for positioning and prevention of foot drop while occupied by resident."

On 06/25/12 at 2:51 PM, Resident #2 was observed in her room sitting in her specialty wheelchair. Her legs were supported with an L-shaped and padded foot cradle attached to the chair and in direct contact with the back of her lower legs. However, the soles of her feet did not reach or touch the foot support platform of the foot cradle. The sole of her left foot was dangling approximately 8 inches from the platform and her right foot was dangling approximately 12 inches from the platform.

On 06/25/12 at 6:00 PM, Resident #2 was observed in the restorative dining room sitting in her specialty wheelchair. There was no change observed in the position of the resident's foot cradle. The soles of the resident's feet did not touch the platform and her feet were dangling.

The resident was again observed in her

F 246

Continued from page -3-

C.) The Leadership Team who is composed of Administrator, Director of Clinical Services, Unit Manager, Assessment Nurse, Social Services Director, Activities Director, Medical Records Director, Business Office Manager, and Dietary Director will complete audits five times a week. The audits will include checking resident for correct foot positioning in wheelchairs. The audits will be for a minimum of one month. With the approval of Quality Assurance Committee (QAC) after one month; the audits will go to one time a week for the next quarter or until the QAC directs otherwise. New Facility Leadership Team members will be educated upon hire on how to conduct audits. New residents will be assessed to assure correct foot positioning.

D.) The Administrator/Director of Clinical Services will review the audits to ensure completion and adequacy. Results of the audits will be reported to the Quality Assurance Committee. Any corrective actions will be implemented as needed. The Medical Director, Administrator, and Director of Clinical Services are responsible for the actions of the QAC. To be completed by July 26, 2012

7/26/12

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wheelchair in the hallway in this position, with her feet dangling and not touching the foot support platform on 06/26/12 at 4:57 PM, on 06/27/12 at 11:44 PM, and on 06/28/12 at 8:25 AM.

On 06/28/12 at 8:30 AM, Nursing Assistant (NA) #1 was interviewed. She stated she routinely worked with Resident #2 and was knowledgeable of the resident's care needs. She stated a foot cradle was attached to the resident's wheelchair by Occupational Therapy so the resident's legs would not dangle. However, NA #1 stated the resident's feet did not reach the platform of the foot cradle. She stated she thought there might be a way to adjust the platform upward but stated she was not sure.

On 06/28/12 at 9:10 AM Resident #2 was observed in the hallway sitting in her wheelchair. The Occupational Therapy Assistant (OTA) and NA #1 were observed adjusting the foot cradle platform so that it supported the soles of the resident's feet. NA #1 stated that the OTA had instructed her how to adjust the foot platform upwards.

On 06/28/12 at 9:30 AM, the OTA was interviewed. She stated that NA #1 had asked her to show her how to adjust the platform of the foot cradle on the resident's wheelchair. She stated it was her expectation that staff adjusted the foot platform to support the resident's feet to prevent foot drop. The OTA stated that staff were instructed how to adjust the foot platform when the specialty wheelchair was obtained for the resident approximately one year ago.

On 06/28/12 at 6:45 PM, the Director of Nursing

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Continued From page 5

was interviewed. She stated she expected nursing assistants to know how to position Resident #2 correctly in her wheelchair, including adjustment of the foot cradle platform to support the resident's feet and prevent her feet from dangling.

F 253 SS=B

483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews, the facility failed to keep sink plumbing fixtures in good repair in resident rooms and bathrooms on two (2) of four (4) halls.

The findings are:

During tours of resident rooms and bathrooms, the following was observed:

On 06/25/12 at 4:05 PM, a sink in room 301 was observed to be dripping and leaking from one handle. A sink in the adjacent bathroom was observed to have yellow stains and green and white stains on the faucet and handles. Both handles and handle housing were loose, one handle was missing a set screw, and rust and corrosion were observed on the drain ring. These conditions were also observed on 06/26/12 at 9:45 AM and on 06/27/12 at 12:10 PM.

On 06/25/12 at 4:14 PM, a sink faucet in room

F 246

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F 253 HOUSEKEEPING & MAINTENANCE SERVICES

F 253

A.) New water faucets are being installed in rooms 202, 204, 301, 305, 307, and 308. The installation will be completed by July 26, 2012.

B.) The Administrator completed an audit of all fixtures in resident rooms and bathrooms. New fixtures were ordered and are being installed in resident rooms and bathrooms where they were in need. The installation will be completed by July 26, 2012. Employees will also be re-educated on the importance of reporting and how to report any malfunctioning equipment such as water faucets. New Employees will also be inserviced on the importance of reporting and how to report any malfunctioning equipment upon hire. Re-education and installment of new fixtures will be completed by July 26, 2012.

C.) The Leadership Team who is composed of Administrator, Director of Clinical Services, Unit Manager, Assessment Nurse,

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F 253	Continued From page 6 202 was observed to be dripping and leaking from one handle. Green stains were observed on the faucet. Both handles and handle housing were loose. Rust, corrosion, and stains were observed on the drain stopper and drain ring. These conditions were also observed on 06/26/12 at 9:20 AM and on 06/27/12 at 11:45 AM. On 06/25/12 at 4:32 PM, a sink in room 305 was observed to be dripping and one handle was leaking. Both handles and handle housing were loose, and had green and white stains. Rust and corrosion were observed on the drain ring. These conditions were also observed on 06/26/12 at 9:50 AM and on 06/27/12 at 12:07 AM. On 06/25/12 at 5:12 PM, a sink faucet in room 308 was observed to be dripping. The faucet and handles had green and white stains, and rust and corrosion were observed on the drain stopper and ring. Both handles and handle housing were loose. Resident #78 was in the room at that time and stated that the faucet "dripped all the time." These conditions were also observed on 06/26/12 at 9:15 AM and on 06/27/12 at 12:05 PM. On 06/25/12 at 5:31 PM, a sink in room 307 was observed to be dripping. Green and white stains were on the faucet and rust and corrosion were observed on the drain ring. These conditions were also observed on 06/26/12 at 9:54 AM and on 06/27/12 at 12:06 PM. On 06/27/12 at 11:45 AM, a sink in room 204 was observed to be dripping. Resident #38 stated the sink had been dripping for weeks. She stated she had told staff about it but it had not been fixed.	F 253	Continued from page -6- Social Services Director, Activities Director, Medical Records Director, Business Office Manager, and Dietary Director will conduct audits five times a week. The audits will include observation to ensure that equipment is functioning correctly. The daily audits will be conducted for at least one month. With the approval of Quality Assurance Committee (QAC) after one month; the audits will go to one time a week for the next quarter or until the QAC directs otherwise. New Facility Leadership Team members will be educated on how to conduct audits. D.) The Administrator/Director of Clinical Services will review the audits to ensure completion and adequacy. Results of the audits will be reported to the Quality Assurance Committee. Any corrective actions will be implemented as needed. The Medical Director, Administrator, and Director of Clinical Services are responsible for the actions of the QAC. To be completed by July 26, 2012. Continued on page -8-	7/26/12

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F 253	Continued From page 7 On 06/28/12 from 4:00 to 4:45 PM, a tour of these rooms was conducted with the Maintenance Director. All the conditions above were observed except in room 204 where the faucet was no longer dripping. He stated the resident in room 204 had asked him to fix her dripping faucet yesterday which he had done. The Maintenance Director stated the faucets all needed replacing. He stated staff were expected to fill out requests for maintenance when repairs were needed but that he had not been made aware of the condition of these faucets.	F 253	Continued from page -7-	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to conduct a significant change Minimum Data Set assessment for one (1) resident with a physical decline, and for two (2) residents who were	F 274	**F274 COMPREHENSIVE ASSESSMENT AFTER SIGNIFICANT CHANGE** A.) The action that is being accomplished for Resident(s) #61, 88, and 57 is a comprehensive assessment for a significant change has been completed as of July 2, 2012. On June 28, 2012 the MDS Nurse was re-educated on the requirements to perform a significant change assessment. She was also re-educated on the MDS 3.0 requirement that a significant change is required when a resident begins coverage under Hospice services. B.) All residents will be reviewed before June 26, 2012 for physical declines to determine if a significant change comprehensive assessment is needed. Also all residents who are on hospice will be reviewed to determine if a significant change comprehensive assessment is needed. Continued on page -9-	

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F 274	Continued From page 8 admitted to hospice, of three (3) residents reviewed for significant changes. Residents #61, #88 and #57. The findings are: 1. Resident #61 was admitted to the facility with diagnoses of diabetes, dementia and anemia. Review of a Quarterly Minimum Data Set (MDS) dated 11/30/11 revealed he was independent with ambulation and needed limited assistance of one person with transfers. The MDS further assessed him as being independent with toileting and was always continent of bladder. Further review of the MDS dated 11/30/12 revealed Resident #61 only required set up when eating and was assessed as having no pressure ulcers. Review of Resident #61's Quarterly MDS assessment dated 02/29/12 revealed the resident had declined in several areas. The MDS assessment indicated ambulation had not occurred during the seven day assessment period and the resident needed extensive assistance with ambulation. The MDS further revealed he needed extensive assistance of one person with eating and extensive assistance of two people with toileting. The MDS assessment further indicated Resident #61 was now frequently incontinent of bladder. He was assessed as having no pressure ulcers. Review of Resident #61's Quarterly MDS dated 05/20/12 revealed he had declined further. Bed transfers had only occurred once or twice in the seven day assessment period and ambulation had not occurred at all. The MDS further	F 274	Continued from page -8- Interdisciplinary Care Plan Team will be re-educated before July 26, 2012 on the requirements to perform a significant change assessment. They will also be re-educated on the MDS 3.0 requirement that a significant change is required when a resident begins coverage under Hospice services. Weekly assessments will be reviewed to see if a resident has had a decline or improvement in two or more areas. In addition, during daily Morning Meeting with the Interdisciplinary Team will review resident weights and recent falls for appropriate interventions to address significant changes. New team members will be inserviced on significant changes during orientation. C.) The MDS Nurse with the Interdisciplinary Team weekly will evaluate residents who are on the Care Plan Schedule to determine if a significant change comprehensive assessment is needed. The MDS will bring to the Morning Meeting for review the reports of the results from the Interdisciplinary Team related to review of resident weights and recent falls for appropriate interventions to address significant changes. Continued on page -10-	

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F 274	Continued From page 9 assessed Resident #61 as now being always incontinent of bladder and as having a stage II pressure ulcer. An observation was made 06/27/12 at 8:10 AM of Resident #61 sitting up in bed; staff had just finished feeding the resident his breakfast. An interview was conducted on 06/28/12 at 8:15 AM with Licensed Nurse # 4. She stated that Resident #61 started having some cognitive changes prior to breaking his hip in February, 2012. She added when he returned from the hospital he was very different and has continued to decline since then. An interview with the MDS Coordinator was conducted on 06/28/12 at 3:35 PM. The MDS Coordinator stated she was unaware a Significant Change MDS was required for Resident #61 as he had been in and out of the hospital a couple of times. An interview was conducted with the Director of Nursing (DON) on 06/28/12 at 4:48 PM. The DON stated she expected a full assessment to be done when the resident experienced a significant change, according to the requirements of Centers for Medicare and Medicaid regulations. 2. Resident #88 was admitted to the facility with diagnoses of end stage dementia, chronic liver disease, and diabetes. Review of Resident #88's Admission Minimum Data Set (MDS) dated 03/23/12 revealed he was not on Hospice at the time of the assessment.	F 274	Continued from page -9- These audits will be reviewed by the Administrator and Director of Clinical Services to ensure resident who have had significant changes are being assessed correctly. These audits will continue for a minimum of one month. With the approval of Quality Assurance Committee (QAC) after one month; the audits will go to one time a month for the next quarter or until the QAC directs otherwise. New Facility Leadership Team members will be educated on how to conduct audits. D.) The Administrator/Director of Clinical Services will review the audits to ensure completion and adequacy. Results of the audits will be reported to the Quality Assurance Committee. Any corrective actions will be implemented as needed. The Medical Director, Administrator, and Director of Clinical Services are responsible for the actions of the QAC. To be completed by July 26, 2012. Continued on page -12-	7/26/12

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CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

(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
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Review of Resident #88's medical record revealed a physician order dated 04/11/12 for a hospice consult. Further review of the resident's medical record revealed his Hospice admission was completed and signed on 04/11/12.

Review of the Quarterly MDS assessment dated 06/12/12 revealed hospice was not checked under the section "Special Treatments, Procedures, and Programs." A significant change MDS assessment was not completed after the resident was admitted to Hospice.

An interview with the MDS Coordinator was conducted on 06/28/12 at 3:35 PM. The MDS Coordinator stated she was unaware a Significant Change MDS was required when a resident was admitted to Hospice services.

An interview was conducted with the Director of Nursing (DON) on 06/28/12 at 4:48 PM.. The DON stated she expected a Significant Change MDS to be completed when a resident was admitted to Hospice, per requirements of Centers for Medicare and Medicaid regulations.

3. Resident # 57 was admitted to the facility with diagnoses including abnormal weight loss, dementia, and diabetes mellitus.

A review of Resident #57's medical record revealed a physician's order dated 05/01/12. The order specified to admit Resident #57 to Hospice services for comfort measures. Further medical record review revealed a Hospice admission form dated 05/01/12 was signed by Resident #57's Responsible Party.

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F 274	Continued From page 11 Resident #57's quarterly Minimum Data Set (MDS) dated 05/01/12 and an annual MDS dated 06/07/12 were reviewed. Neither MDS reflected Hospice services were initiated or provided for Resident #57. Care Area Assessments (CAA) were reviewed for the 06/07/12 annual MDS. No CAA addressed end of life care being provided for Resident #57. An interview with the MDS Coordinator was conducted on 06/28/12 at 3:35 PM. The MDS Coordinator stated she was unaware a Significant Change MDS was required when a resident was admitted to Hospice services. An interview was conducted with the Director of Nursing (DON) on 06/28/12 at 4:48 PM. The DON stated she expected a Significant Change MDS to be completed when a resident was admitted to Hospice, per requirements of Centers for Medicare and Medicaid regulations.	F 274	Continued from page -10-	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical and facility record reviews, the facility intended to provide thin liquids to one (1) of one	F 309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** A.) (1) Licensed Nurse (LN) #3 (Nurse for Resident #61) was immediately re-educated upon notification by the surveyor on June 28, 2012, regarding all residents on thick liquids are to receive the correct liquid consistency; and any special requirements for any resident prior to medication administration; and where to locate reference tools. (2.) On June 28, 2012 Resident #61's bowel movement records were reviewed and the resident had not exceeded three days between bowel movements since June 18, 2012 and Resident #75 had not exceeded three days between bowel movements since June 12, 2012. Both residents did not require any interventions as of the time of survey. Continued on page -13-	

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(1) residents observed during medication administration who required thickened liquids. (Resident #61). The facility also failed to provide interventions for two (2) of eight (8) residents that went greater than three (3) days without bowel movements. (Residents #75 and #61).

The findings are:

1. Resident #61 was admitted to the facility with diagnoses including dysphagia and a history of pneumonia secondary to aspiration.

A review of Resident #61's medical record revealed a physician's order dated 05/16/12 that specified to change the resident's diet to pureed foods with nectar thick liquids. Further medical record review revealed a physician's progress note dated 05/17/12. The progress note indicated the resident had difficulty swallowing and had a history of pneumonia probably secondary to aspiration.

The latest Minimum Data Set (MDS) dated 05/20/12 indicated moderate impairment of cognition. The MDS specified Resident #61 required extensive staff assistance with eating and had difficulty swallowing.

A review of a Speech Therapist consultation dated 06/13/12 revealed Resident #61 demonstrated impaired swallowing and was on the least restrictive diet of pureed food with nectar thick liquids. The report specified the resident tolerated the nectar thickened liquids with no signs or symptoms of aspiration.

An observation on 06/26/12 at 4:49 PM revealed

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B.) (1) The Licensed Nurses will be re-educated on the location of the list on the medication cart that references all residents on thickened liquids. Nurses will be reminded their responsibility to check the list prior to giving liquids to resident during med pass or any other time. New Nurses will be inserviced on correct thick liquids procedures upon hire. (2) The Licensed Nurse will review the bowel movement report daily. Any resident identified with concerns will have the bowel protocol initialed as indicated. Director of Clinical Services or the Unit Manager will follow up daily to ensure the bowel movement report is reviewed and correct action/intervention has been implemented. Licensed Nurses will be re-educated on the importance of the bowel movement report and following the bowel protocol. Certified Nursing Assistants will be re-educated on the importance of documenting bowel movements in the resident's medical record. The re-education will be completed by July 26, 2012. . New employees will be inserviced on bowel protocol and documentation during orientation upon hire.

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F 309	Continued From page 13 Licensed Nurse (LN) #3 administered medication to Resident #61. LN #3 administered a crushed pill mixed with applesauce to Resident #61, then offered a cup of thin water to the resident with the intent of administering the water. When alerted to the fact the resident required thickened liquids, LN #3 discarded the thin water and provided nectar thickened water to Resident #61. An interview was conducted with LN #3 immediately following the incident. LN #3 stated a book was provided on each medication cart that specified which residents required thickened liquids. LN #3 then looked in the book and confirmed Resident #61 required nectar thickened liquids. An interview with the Director of Nursing on 06/28/12 at 11:22 AM revealed her expectation was for nurses to look at the book provided on medication carts to ensure physician's orders were followed. An interview with the Speech Therapist on 06/28/12 at 2:11 PM revealed Resident #61 was at great risk for aspiration. She stated it was very important to provide thickened liquids to promote maximum safety for the resident. 2. The facility's policy entitled Bowel Movement Assessment dated 03/2012 read in part, "If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders." Resident #75 was admitted to the facility on 02/17/12 with the diagnoses of dementia and	F 309	Continued from page -13- C.) (1). Medication Pass observations will be completed weekly to ensure thickened liquids are given according to physician orders. These observations will be conducted by Administrator, Director of Clinical Services or Unit Manager. The observations will be made of five randomly chosen nurses per week and will include each nurse administering medications to both a resident requiring thickened liquids and a resident requiring regular liquids. The thick liquids protocol audits will continue for a minimum of one month. With the approval of Quality Assurance Committee (QAC) after one month; the audits will go to one time a month for the next quarter or until the QAC directs otherwise. (2) The Administrator, Director of Clinical Services or Unit Manager will conduct audits daily to ensure the bowel movement reports are being reviewed and that all residents who are shown on the bowel movement report to have exceeded three days between bowel movements have had the bowel protocol initiated and followed. The bowel protocol audits will continue for minimum of one month. With the approval of Quality Assurance Committee (QAC) after one month; the audits continued on page -15-	

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F 309	Continued From page 14 dysphasia. Review of Resident #75's most recent quarterly Minimum Data Set (MDS) dated 05/17/12 assessed her as having long and short term memory loss and was severly impaired for daily decision making. The MDS further assessed Resident #75 as always incontinent. Review of Resident #75's bowel records revealed she did not have a bowel movement for nine days, 05/31/12 through 06/08/12. Further review of Resident #75's bowel records revealed she did not have a bowel movement for six days, 06/13/12 through 06/18/12. Review of Resident #75's Medication Administration Record revealed she was not given a laxative or a suppository after three consecutive days of having no bowel movement. An interview was conducted on 06/28/12 at 10:05 AM with Nursing Assistant (NA) #3. She reported that she always documented bowel movements in the computerized medical record. She further stated that if a resident had not had a bowel movement in three days the nurses would ask the NAs about it to make sure the resident had not had a bowel movement. During an interview on 06/28/12 at 10:08 AM Licensed Nurse #4 stated the nurses were responsible for pulling the seventy-two (72) hour bowel movement report. This was a report of all residents who have not had a bowel movement in the last 72 hours. An interview was conducted on 06/28/12 at 11:16 AM with the Director of Nursing (DON). The DON stated the nurses were expected to monitor the	F 309	continued on page -14- will go to one time a month for the next quarter or until the QAC directs otherwise. D.) The Administrator/Director of Clinical Services will review the audits to ensure completion and adequacy. Results of the audits will be reported to the Quality Assurance Committee. Any corrective actions will be implemented as needed. The Medical Director, Administrator, and Director of Clinical Services are responsible for the actions of the QAC. To be completed by July 26, 2012. Continued on page -17-	7/28/12 7/26/12

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F 309	Continued From page 15 72 hour bowel movement report. She further stated it was her expectation that the nurses would have assessed the resident, followed the bowel protocol and administered a laxative to the resident when there was no bowel movement for three (3) consecutive days. 3. The facility's policy entitled Bowel Movement Assessment dated 03/2012 read in part, "If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders." Resident #61 was admitted to the facility with the diagnoses of dysphasia, diabetes mellitus and dementia. Resident #61's most recent quarterly Minimum Data Set (MDS) dated 05/20/12 revealed he had moderated cognitive impairment and was always incontinent. Review of Resident #61's bowel records revealed he did not have a bowel movement for seven days, from 05/30/12 through 06/05/12. Bowel record further indicated he did not have a bowel movement for five consecutive days, from 06/08/12 through 06/12/12. Review of Resident #61's Medication Administration Records revealed he did not receive a laxative or a suppository after three (3) consecutive days of not having a bowel movement. An interview was conducted on 06/28/12 at 10:05 AM with Nursing Assistant #3. She reported that she always documented bowel movements in the computerized medical record. She further stated	F 309		

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F 309	Continued From page 16 that if a resident had not had a bowel movement in three days the nurses would ask them about it to make sure the resident had not had a bowel movement. During an interview on 06/28/12 at 10:08 AM Licensed Nurse #4 stated the nurses were responsible for pulling the seventy-two (72) hour bowel movement report. This was a report of all residents who have not had a bowel movement in the last 72 hours. An interview was conducted on 06/28/12 at 11:16 AM with the Director of Nursing (DON). The DON stated the nurses were expected to monitor the 72 hour bowel movement report. She further stated it was her expectation that the nurses would have assessed the resident, followed the bowel protocol and administered a laxative to the resident when there was no bowel movement for three (3) consecutive days.	F 309	Continued from page -15-	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** A.) The action that is being accomplished for Resident #3 is Licensed Nurse (LN) #1 was re-educated on June 28, 2012 on the correct procedure for cleaning blood glucometer in accordance with CDC guidelines. All blood sugar monitoring devices are to be cleaned with a bleach solution following using the machine on each resident Continued on page -18-	

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actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record reviews, the facility failed to disinfect a blood glucose monitor (glucometer) prior to use for one (1) of eight (8) residents (Resident #81).

The findings are:

A review of a facility policy entitled "Blood Glucose Monitoring" dated 03/12 revealed the directive that staff "cleanse glucometer after each resident use with a dilute bleach solution of 1:10 (one part bleach to 9 parts water) (or) utilize approved disinfectant wipes per manufacturer's

B.) All Licensed Nurses have been re-educated on correct procedure for cleaning blood sugar monitoring devices in accordance with CDC guidelines including: All blood sugar monitoring devices are to be cleaned with a bleach solution following using the machine. New hired Licensed Nurses will be inserviced on correct procedure for cleaning blood sugar monitoring devices in accordance with CDC guidelines during orientation.

C.) The Administrator, Director of Clinical Services and/or the Unit Manager will observe five Licensed Nurses per week across all shifts performing blood glucose monitoring including machine disinfecting for four weeks, then observe three Licensed Nurses per week for one month, then one Licensed Nurse per week for four weeks. With the approval of Quality Assurance Committee (QAC) the audits will go to one time a quarter or until the QAC directs otherwise.

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F 441	Continued From page 18 instructions." On 06/26/12 at 4:35 PM, Licensed Nurse (LN) #1 was observed removing a glucometer from a drawer of the medication cart and placed it on top of a facial tissue on the cart. LN #1 then removed a monitor strip, alcohol pad, gauze pad and a sterile lancet. The monitor strip was inserted into the glucometer and after applying an antimicrobial hand sanitizer and donning gloves, LN#1 approached Resident #81 with the glucometer. A fingertip of Resident #81 was pricked by LN #1 and a drop of blood obtained that was placed against the end of the monitor strip. After the blood glucose result was obtained, LN #1 applied the gauze pad to the resident's finger and removed the monitor strip from the glucometer for disposal. LN #1 removed her gloves, applied hand sanitizer, and returned the glucometer to the medication cart drawer. On 06/26/12 at 4:57 PM, LN #1 was observed removing a glucometer from a drawer of the medication cart and placed it on top of a facial tissue on the cart. LN #1 removed the glucometer closest to the front of the drawer and stated that this was the monitor she used on Resident #81. LN #1 then removed from a container in the same drawer a monitor strip, alcohol pad, gauze pad and a sterile lancet. The monitor strip was inserted into the glucometer and after applying hand sanitizer and gloves, LN #1 approached Resident #3. LN #1 was asked by the State Surveyor to stop from proceeding with blood glucose monitoring and LN #1 stepped away from the resident. On 06/26/12 at 5:00 PM, LN #1 was interviewed.	F 441	Continued from page -18- D.) The Administrator/Director of Clinical Services will review the audits to ensure completion and adequacy. Results of the audits will be reported to the Quality Assurance Committee. Any corrective actions will be implemented as needed. The Medical Director, Administrator, and Director of Clinical Services are responsible for the actions of the QAC. To be completed by July 26, 2012.	7/26/12

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

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She stated that she should have disinfected the glucometer after using it on the previous resident, according to facility policy, but that she forgot.

On 6/26/12 at 5:01 PM, LN #1 removed from the medication cart an individually wrapped germicidal disposable wipe effective against blood-borne pathogens and wiped down all the surfaces of the glucometer. LN #1 obtained another monitor strip and inserted it in the glucometer. LN #1 obtained another sterile single-use lancet, gauze pad and alcohol pad and after applying hand sanitizer and gloves approached Resident #3. LN #1 applied the lancet to the resident's finger tip and obtained a drop of blood that was placed against the end of the monitor strip. After the blood glucose result was obtained, LN #1 applied the gauze pad to the resident's finger and removed the monitor strip from the glucometer for disposal. LN #1 removed from the medication cart drawer another individually wrapped germicidal disposable wipe and wiped all the surfaces of the glucometer. LN #1 removed her gloves and applied hand sanitizer before returning the glucometer to the drawer in the medication cart.

On 06/28/12 at 4:40 PM, the Director of Nursing (DON) was interviewed. The DON stated she expected nursing staff to disinfect glucometers with a germicidal wipe after each use with a resident, according to the facility policy, as all nurses had been inserviced to do.