STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 observations and staff interviews the facility failed to treat residents in a dignified manner by serving residents on Styrofoam plates for 2 of 2 residents observed (Resident # 's 153 and # 157). Findings include: 1. Lunch meal observations were conducted on the 200 Hall in the Day Room on 7/09/12 at 12:50 PM. Resident # 153 received the meal on a Styrofoam plate with plastic utensils. Resident #153 was interviewed on 7/09/12 @ 1:10 PM regarding whether the resident knew the reason for having received the Styrofoam plate. The resident was unaware as to why the meal was received on a Styrofoam plate. A staff interview with the Charge Nurse was conducted 7/09/12 at 1:15 PM regarding the reason the resident # 153 received a disposable. The nurse stated, "(The resident) is not on isolation, and does not have an infection. I don't know why (the resident) is getting a disposable plate." 2. Observations were conducted on 7/10/12 at 11:00 AM during the lunch meal. A Styrofoam tray with plastic utensils and a Styrofoam plate was observed in the tray cart for resident # 157.	F 241	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Winston-Salem Nursing & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." **F241** 1.Residents 153 & 157 interviewed to assuring wellbeing. Resident 153 & 157 are receiving meals using standard dishes and utensils. 2. Any resident dining in the facility can be affected by this practice. Therefore, the CDM/RD/DON has reviewed resident preferences regarding meal service. The CDM will audit meal service wares and set par level with Administrator. 3.An in-service on 7/12/12 was conducted by RD for Dietary Staff regarding meal service preferences. The Administrator provided in-service and met with CDM on 7/12/12 regarding maintaining a par level of standard dishes and dining utensils and ordered items as appropriate. 4.The CDM will do a monthly audit of meal service wares and review at the QA meeting for the first two months. Thereafter the CDM will review the par levels with the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 8/7/12

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

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F 241	Continued From page 1 Resident #157 was not interviewable according to the Direct Care staff, and therefore could not indicate the reason the disposable plate was received. The Direct Care staff member who was feeding the resident did not know why the resident received a Styrofoam /disposable plate. A staff interview was conducted with the Dietary Manager on 7/13/12 @ 3:30 PM, regarding the reason resident #153 and resident #157 received their lunch meal on 7/9/12 in disposable dinnerware. The Dietary Manager indicated, "We had a plate shortage, and we ran out of dinner plates to serve on, because we still had a lot of the dirty breakfast trays out on the floors, and did not have enough plates to use." When asked if the Dietary Department had a full supply of plates to serve all residents in the building. The Dietary Manager stated, "We have more than we need to serve the 200 residents that we have on the floor, but when trays do not come back after a meal, that puts us to where we run close to running out of plates, or we run out. It's happened a couple of times in the last two months, so we ordered 2 cases of 48 plates/ case three weeks ago, and we have not received them yet. I do not have a copy of the order or the invoice. I am still operating under the past facility owner 's policies. I do not have a specific amount of plates I am supposed to keep on hand. In the past in other buildings, I have kept on hand an extra 50 % of what our building capacity is for a backup contingency supply. I have discussed this plan with our Administrator this week, and that will be what I will do in the future. I started the process yesterday 7/12/12 by putting an order in with the Food supplier." (See copy of Confirmation order). On 7/09/12 I sent my Assistant Dietary Managers	F 241	Administrator for reorder as necessary. The CDM, Unit Managers, RD, DON will conduct dining room/room rounds 3 times per week for 8 weeks to assess following meal preferences. Results of audits will be reviewed by the CDM at the QA monthly meeting times 3 months.	7/30/12

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F 241	Continued From page 2 to the floors to do a sweep of the building to pick up the access soiled dishes and utensil, so we could wash them and replenish the supply on the floors. I did not know (resident #153 and resident #157) had received the disposable plates until after the lunch meal was over. The staff on the line made the decision to send the disposable plates, because that is all they had at the time to serve on." A staff interview was conducted on 7/13/12 at 4:25 PM with the Corporate Registered Dietitian (RD) Consultant regarding the lack of sufficient dinnerware to serve the entire population in the facility. The RD indicated, "We do not have a par level for the facility nor a policy on the amount of dishes to have on hand."	F 241		
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	F 279	F279 1.The care plan for resident 67 was reviewed and updated by the IDT on 7/12/12. 2.Any resident requiring splinting can be affected by this practice. Therefore, the IDT and MDS staff have reviewed residents with splints for need of the splints and care planning goals. 3.The Corporate MDS consultant will conduct an in-service for the facility MDS team regarding goals for splinting by 8/10/12. 4.The DON will audit the care plans of residents with new orders for splints for accuracy of the care plan. This will be done for 8 weeks. The results of the audits will be reviewed at the monthly QA meeting by the DON times three months.	8/10/12

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F 279	Continued From page 3 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review, the facility failed to include the use of a splint on the careplan, for one (1) of three (3) residents with splints. (Resident #67) The findings were: Resident #67 was re-admitted to the facility on 2/16/11 with diagnoses of Convulsions, Alzheimer ' s, Diabetes type II, Atrial Fibrillation, Hypertension and Dysphagia. Review of the Minimum Data Set (MDS), a quarterly, dated 5/10/12, recorded no restorative treatments as being provided during this assessment timeframe. Resident #67 was assessed as having impairment in movement of all extremities. Review of the careplan for Resident # 67, was revised on 3/1/12. One of the problems included "Potential for decline in present level of function related to " (no response was provided). Review of the goal for this problem, was the resident would not experience a decline in their level of functioning through the next review. Review of the approaches included passive range of motion (PROM) to be provided by the Restorative staff. This was to be provided on a daily basis. The use of the ordered splint was not included in the approaches.	F 279		

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F 279	Continued From page 4 An interview was conducted on 7/12/12 at 12:30 PM with MDS nurse #1. During this interview, MDS nurse #1 explained hemiplegia, with an unspecified side, was related to the problem of a potential for decline in functioning. Further interview revealed MDS nurse #1 would include all extremities to receive PROM. During this interview, MDS nurse #1 was questioned about the use of a splint. The response given was she did not recall the resident having a brace/splint. After reviewing the physician's order for the splint, MDS nurse #1 confirmed the splint for the right hand should have been included on the care plan.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to provide passive range of motion by restorative services according to the careplan for one (1) of three (3) sampled residents with contractures. The findings were: Resident #67 was re-admitted to the facility on 2/16/11 with diagnoses of Convulsions, Alzheimer ' s, Diabetes type II, Atrial Fibrillation, Hypertension and Dysphagia. Review of the Minimum Data Set (MDS), a	F 282	**F282** 1.Resident 67 had their care plan reviewed and care is provided according to the plan of care. Resident 67 had therapy evaluation 7/10/12 and Occupational Therapy plan of care implemented with regard to ROM and Splinting. 2.Any resident requiring restorative nursing services can be affected by this practice therefore, the DON, Unit Managers, Restorative Assistants and Therapy met on 7/10/12 with ongoing meetings through 7/31/12 to review and identify residents on restorative and in need of restorative. The care plans were reviewed for these residents and the restorative case load reviewed for accuracy.	

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F 282	Continued From page 5 quarterly, dated 5/10/12, recorded no restorative as being provided during this assessment timeframe. Resident #67 was assessed as having impairment in movement of all extremities. Review of the careplan for Resident # 67, was revised on 3/1/12. One of the problems included "Potential for decline in present level of function related to " (no response was provided). The goal for this problem was for the resident to not experience a decline in their level of functioning through the next review. Review of the approaches included passive range of motion (PROM) to be provided by the Restorative staff. This was to be provided on a daily basis. An interview was conducted on 7/11/12 at 5:15 PM with Administrative nursing staff #1 in regards to the restorative nursing program. During this interview, it was explained restorative aides had provided PROM and splint treatments. Currently, there was one Restorative Nursing Assistant, who works with the residents. The caseload for restorative consisted of the residents that were immediately discharged from therapy. The aides on the floor provided the restorative treatments, such as PROM and splints. The Administrative nursing staff #1 explained the Restorative aides applied splints every day until 5/30/12. After that date, it was switched to the aides on the floor. On 7/12/12 at 9:10 AM, an interview with floor nurse #1, revealed there used to be restorative staff that performed PROM. Further interview revealed she was not aware of restorative staff currently working with the residents.	F 282	3.The DON provided an in-service for the restorative nursing staff and MDS staff to discuss the procedure for placing residents on and taking them off restorative and clarification of maintenance restorative and revision of care plan as appropriate on 8/6/12. 4.The DON will meet with the restorative nursing staff and Unit Managers and care plan team to ascertain compliance with the restorative program and documentation and updates for restorative services weekly times 8 weeks. Results of the audits will be reviewed by the DON times 3 months at monthly QA meeting.	8/10/12

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F 282	Continued From page 6 An interview was conducted on 7/12/12 at 12:30 PM with MDS nurse #1. During this interview with MDS nurse #1 revealed the restorative program was "revamped" several months ago. Resident #67 was removed from restorative nursing. The MDS nurse #1 confirmed the careplan did identify restorative staff were to provide the PROM for Resident #67.	F 282		
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, staff interview and medical record reviews the facility failed to provide personal hygiene care to dependent residents for one (1) of ten (10) sampled residents dependent for care. (Resident #193) and hand hygiene for Resident #67 for one (1) of three (3) sampled residents with contractures. The findings were: 1. Resident #193 was admitted to the facility on 1/23/2012 with diagnoses including Dementia, Fractured hip, Hypertension and Glaucoma. Review of the Minimum Data Set (MDS) dated 4/23/12 assessed Resident #193 as requiring extensive assistance with personal hygiene and	F 312	**F312** 1.Resident 193 is provided bathing and nail care as per their care plan. Resident 67 is provided hand hygiene as per their care plan. 2.Any resident requiring nail care and hand hygiene can be affected by this practice. Therefore, the IDT met on 8/1/12 and discussed ADL of the facilities residents and care plans updated as needed. 3. SDC in-serviced nurses and nursing assistants on 8/1/12 as well on nail care and hand hygiene. 4.The DON, SDC, Unit Managers will conduct rounds 5 times per week for 8 weeks to assure nail care and hand hygiene is provided to dependent residents. Results of these audits will be reviewed at the QA meeting by the DON monthly times 3 months.	8/10/12

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F 312	Continued From page 7 total dependence with bathing. Resident #193 had short and long term memory impairment and could not be interviewed. Review of the careplan, with a revision date of 4/25/12, revealed a problem of requiring assistance with and/or provision for Activities of Daily Living (ADLs). The goal for Resident # 193 would be to experience cleanliness and comfort each day. The approaches for staff to follow included assisting the resident with AM/PM (morning/evening) care and record completion at least every morning and evening. A bath/shower was to be provided every Monday, Wednesday, and Friday on the evening shift. Observations on 7/10/12 at 11:00 AM revealed Resident #193 had black substance underneath her fingernails on both hands. Observations on 7/11/12 at 8:15 AM revealed Resident #193 had black substance underneath her fingernails on both hands. Continued observation revealed Resident #193 was eating breakfast, at times using her hands, and then licking her fingers. Observations of Resident #193 on 7/12/12 at 4:00 PM revealed Resident #193 was eating crackers with her hands, and her fingernails had a black substance underneath the nails on both hands. Interview on 7/12/12 at 4:30 PM with nursing assistant # 1 revealed she was caring for Resident #193 that day. Continued interview provided information regarding the care that was provided to Resident #193, which included AM/PM care. This was further explained as	F 312		

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F 312	Continued From page 8 washing the resident ' s face and hands, getting them dressed/undressed and getting them up/assisted to bed. Nursing assistant #1 explained nail care would be done during showers. During the interview, nursing assistant #1 was questioned as to when Resident #193 would receive a shower. The response provided was she was not sure when the resident ' s shower was supposed to be done. She was a "floater" and worked different places. Interview on 7/13/12 at 10:48 AM with Administrative nursing staff #1 revealed nail care would be provided when the aide gave the shower as scheduled. Continued interview revealed, Resident #193 would refuse care. The procedure for resident refusals was explained by this Administrative nursing staff #1. If they (residents) refuse two times, the aides were to report the refusal to the floor nurse. The floor nurse was to ask the resident to allow care to be provided. Further interview revealed the facility now had a shower team in place. When asked if Resident #193 received showers by the shower team, the response was " no, the aides on that floor would give showers " . On 7/13/12 at 11:37 AM, nursing assistant ' s documentation was reviewed with MDS nurse #1. The " smart charting " in the electronic chart, of the care provided to Resident # 193 was reviewed. There were no refusals documented by the nursing assistants for the days of 7/9, 7/10, or 7/11. Review of the ADL Assistance and Support flowsheet, in the electronic chart, revealed the scheduled showers were documented as given, with no refusals on 7/9/12 and 7/11/12.	F 312		

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F 312	Continued From page 9 An interview was conducted on 7/13/12 at 11:25 AM with nursing assistant #2 regarding refusals of care by Resident # 193. During the interview, nursing assistant #2 stated she had worked with this resident on multiple occasions. Resident # 193 would refuse care at times. She further commented, she could go back and the resident would allow care. Additional documentation was provided on 7/13/12 by Administrative nursing staff #1, to show Resident #193 refused care. Review of the information included a printout of "Completed Care Tasks" for the dates of the survey. Review of the dates of the survey revealed care was refused on the following times: 7/8/12 at 0133 AM, 7/9/12 at 0405 AM and 7/13/12 at 0451 AM. There were no other refusals of personal care and/or am/pm care for the days of the survey. Review of the documentation on this printout revealed the resident had care documented as being provided on the other two shifts. 2. Resident #67 re-admitted to facility on 2/16/11 with diagnoses of Convulsions, Alzheimer ' s, Diabetes type II, Atrial Fibrillation, Hypertension and Dysphagia. Review of the Minimum Data Set (MDS) dated 5/10/12 documented Resident #67 required total assistance of two persons for provision of personal hygiene, bathing, and toileting and bed mobility. Review of Resident #67 ' s careplan, with a review date of 5/11/12, revealed she required assistance with and/or provision for Activity of	F 312		

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F 312	Continued From page 10 Daily Living (ADLs). The goal would be for the resident to experience cleanliness and comfort each day. The approaches included the staff were to assist Resident #67 with AM/PM (morning/evening) care and record completion at least every morning and evening. Resident # 67 would receive a bath/shower every Monday, Wednesday and Friday on day shift. Review of the electronic chart for documentation of AM/PM care for Resident #67 revealed it had been provided during the timeframe of 7/9/12 to 7/12/12. Observations on 7/11/12 at 8:40 AM revealed Resident #67 had fingernails with a black substance under them. Both hands were observed to be contracted with long fingernails. The nails were pressing into the palm of the left hand. Both hands had an odor, and some type of white powdery substance caked inside the palms. Interview on 7/12/12 at 11:50 AM with nursing assistant #4 revealed she cleans Resident #67 ' s hands but it keeps an odor. Continued interview revealed the resident perspired a lot and nail care would be provided by the nurses since Resident #67 was a diabetic. Interview on 7/12/12 at 4:35 PM with nursing assistant #3 revealed she has taken care of Resident # 67 several times. During this interview she revealed personal hygiene would be provided during AM/PM care or on their scheduled bath days. Further interview revealed AM/PM care would consist of washing the resident ' s face and hands, dressing/undressing the resident and either getting them up or putting	F 312		

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WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 312	Continued From page 11 them to bed. Nail care would be provided on their bath days. An interview with Administrative nursing staff # 1, on 7/13/12 at 10:50 AM revealed the expectation for ADL cleanliness of hands would be to provide am/pm care, clean resident ' s hands and inspect for any odors. Further interview revealed Resident #67 is total care, and the staff would do bed baths. The hands would be cleaned during the bath.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff interview and nurse practioner interview, the facility failed to follow recommendations to apply splints to both hands for one (1) of three (3) sampled residents with contractures. (Resident #67) The findings were: Resident #67 was re-admitted to facility on 2/16/11 with diagnoses of Convulsions, Alzheimer ' s, Diabetes type II, Atrial Fibrillation, Hypertension and Dysphagia.	F 318	**F318** 1.Resident 67 is receiving therapy and splinting per physicians orders. 2.Any resident requiring splinting can be affected by this practice. Therefore the IDT, Therapy and care plan teams will audit the splinting programs currently in place and	

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F 318	Continued From page 12 Review of the Minimum Data Set (MDS), a quarterly, dated 5/10/12, recorded no restorative treatments as being provided during this assessment timeframe. Resident #67 was assessed as having impairment in movement of all extremities. Review of the careplan for Resident # 67, was revised on 3/1/12. One of the problems included "Potential for decline in present level of function related to " (no response was provided). Review of the goal for this problem, was the resident would not experience a decline in their level of functioning through the next review. Review of the approaches included passive range of motion (PROM) to be provided by the Restorative staff. This was to be provided on a daily basis. The use of the ordered splint was not included in the approaches. Review of the Occupational Therapy (OT) Discharge Summary, dated 7/28/10 documented Resident #67 was to wear bilateral upper splints. The splints were provided and palm guards were on back order. Further review revealed education was provided to Nursing on splint application, and a return demonstration was noted. Review of the 7/1/12 monthly orders, signed by the nurse practioner, included an order to apply a splint to the right hand in the morning and off in the afternoon. The splint was to be worn no more than eight hours. Observation on 7/10/12 at 9:00 AM revealed Resident #67 was not wearing a splint on either hand.	F 318	therapy screened residents with potential for decline and placed on therapy as appropriate. 7/10/12-7/30/12. To assure ongoing screens and therapy as needed therapy team to screen and evaluate quarterly. 3.The facility nurses, restorative nursing assistants and floor nursing assistants will be in-serviced by the SDC on 8/1/12 regarding appropriate application of splints. 4.The DON, SDC and Unit Managers will audit residents receiving splinting for following physicians orders 5 times per week for 8 weeks. Results of the audits will be reviewed at the QA meeting monthly times 3 months by the DON.	8/10/12

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F 318	Continued From page 13 Observation on 7/11/12 at 8:40 AM revealed a splint was applied to left hand of Resident #67. Observation on 7/11/12 at 3:40 PM revealed a splint remained on left hand of Resident #67. Observation on 7/12/12 at 1:30 PM revealed Resident #67 was not wearing a splint on either hand. Observation on 7/12/12 at 4:30 PM revealed Resident #67 had a splint on each wrist/hand. The fingers on the right hand remained curled into the palm, instead of open with placement of the splint in the palm. An interview was conducted on 7/11/12 at 5:15 PM with Administrative nursing staff #1 in regards to the restorative nursing program. During this interview, it was explained restorative aides had provided PROM and splint treatments. Currently, there was one Restorative Nursing Assistant, who works with the residents. The caseload for restorative consisted of the residents that were immediately discharged from therapy. The aides on the floor provided the restorative treatments, such as PROM and splints. The Administrative staff #1 explained the Restorative aides applied splints every day for Resident #67, until 5/30/12. After that date, it (restorative therapy) was switched to the aides on the floor. Interview on 7/12/12 at 10:05 AM with the Nurse Practioner revealed the resident should have the splint on her right hand. During this interview, the OT discharge summary was reviewed with the Nurse Practioner. Further interview revealed she	F 318		

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F 318	Continued From page 14 was not aware the OT had originally ordered Resident #67 to have splints on both hands. Interview with aide #4 on 7/12/12 at 11:50 AM revealed she was aware a splint should be applied during care. Continued interview revealed the splint should be applied to the left wrist. Further interview revealed she usually applied the splint around 12 Noon and the evening shift would remove it. An interview was conducted on 7/12/12 at 12:30 PM with MDS nurse #1. During this interview, MDS nurse #1 explained hemiplegia, with an unspecified side, was related to the problem of a potential for decline in functioning. During this interview, MDS nurse #1 was questioned about the use of a splint. The response given was she did not recall the resident having a brace/splint. On 7/12/12 at 12:50 PM, an interview was conducted with the therapy manager regarding the original plan of care for bilateral splints to both hands. During this interview, it was revealed no further information about the splints could be provided. The therapy manager explained the plan of care for Resident #67 was before this he had started to work at the facility. He further explained, any therapy notes kept in their department would have been gone by now. Additionally, the therapy manager stated he did not have any recent requests for a screen or evaluation for Resident #67. Interview on 7/12/12 at 12:50 PM with the therapy regional manager revealed, there was a time lapse of two years from the time of the original splint order and the start of their therapy	F 318		

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F 318	Continued From page 15 management. Further interview revealed the therapy department could not provide any information to show the palm guards were received, or where second splint may have gone. The OT note was reviewed by the therapy manager and the regional therapy manager. After reviewing the records, both managers agreed splints for Resident #67 should be on both hands. The therapy managers concluded Resident #67 would receive an evaluation for the potential need for splints and therapy. On 7/12/12 at 4:35 PM, an interview was conducted on the 3-11 shift with nursing assistant #3. The interview covered the issue regarding the use of splints for Resident # 67. During this interview, nursing assistant #3 revealed she had worked with Resident #67 on previous occasions and did not remember her having any splints. The last time she worked with the resident was about 2 wks ago and there were no splints. Continued interview revealed Resident #67 had splints applied by therapy (on 7/12/12) and she would remove them after two hours.	F 318		
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	F 329	F329 1.Resident 67 is receiving medications per the Physicians orders. 2.Any resident receiving medications requiring medication discontinuation can be affected by this practice. Therefore, the DON, SDC and Unit Managers audited the pharmacy consult reports on 7/13/12. 3.The SDC conducted an in-service on 8/2/12 for staff nurses and Unit Managers regarding the procedure for reconciliation of the pharmacy recommendations. 4.The DON and SDC will audit the pharmacy recommendations for accurate follow through monthly times 4 months. Results of the audits will be reviewed at the QA meeting times 4 months by the DON.	8/10/12

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F 329	Continued From page 16 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 drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, nurse practioner interview and pharmacy consultant interview, the facility failed to discontinue a medication per pharmacy recommendation and nurse practioner ' s order for one (1) of ten (10) sampled residents. Resident #67 The findings were: Resident #67 was re-admitted to facility on 2/16/11 with diagnoses of Convulsions, Alzheimer ' s, Diabetes type II, Atrial Fibrillation, Hypertension and Dysphagia. Medical record review of a pharmacy recommendation dated 4/26/12 revealed Ferrous Sulfate (Iron) tablet was to be discontinued. The recommendations were due to labwork findings for the hematocrit and hemoglobin were within normal limits on 4/4/12. Further review revealed	F 329		

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F 329	Continued From page 17 recommendations for the physician to review the order and discontinue the drug due to potential side effects of the medication. The pharmacy listed side effects of constipation and gastric upset. The nurse practioner had signed and agreed with the pharmacy recommendations to stop the drug. The date of the nurse practioner ' s signature was 5/29/12. Review of the monthly orders for the months of June and July 2012 revealed the order for the Iron tablet had not been discontinued on the orders. The orders had been checked as being correct, by a licensed nurse, on 5/30/12 for the June orders and 6/25/12 for the July orders. Review of the June and July 2012 monthly orders had been signed by the nurse practioner. Review of the Medication Administration Record (MARs) was conducted on 7/11/12. The review of the MARs for June revealed the Iron tablet had been given the entire month. Review of the MARs for July 2012 revealed the Iron tablet had been given for the dates of July 1 through July 11, 2012. Interview on 7/11/12 at 3:30 PM with nurse #2 revealed the pharmacy recommendation had not been noted by a nurse. During this interview, nurse #2 confirmed the pharmacy recommendation would be considered an order, and a nurse should have noted the order. Nurse #2 explained the procedure for processing the pharmacy recommendation consisted of the following: 1. the physician/nurse practioner received the recommendations, 2. it (recommendation) goes to the nurse for verification, 3. pharmacy would be notified by	F 329		

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F 329	Continued From page 18	F 329		

nursing, and 4. a ward clerk would file it. Continued interview revealed there had been staffing changes for the unit manager since May 2012 and the recommendation must have been missed.

Interview with Administrative nursing staff #1 on 7/11/12 at 5:10 PM regarding the process for pharmacy recommendations to the MD were explained as follows: First, a pharmacy consultant comes into the facility each month, prints the recommendations out and gives the copies to the director of nursing. Second, the physician/nurse practioner would review the recommendations and either agreed and/or commented. It was then signed and dated. The last step would be made by the nurse for that resident. The nurse would be expected to write a telephone order for the recommendation.

During an interview on 7/11/12 at 5:10 PM with Administrative nursing staff #1 the process for checking the monthly orders was presented. Administrative staff #1 explained the orders were checked at the end of each month. The Medication Administration Records (MARs) for the next month were checked using the current orders. The new monthly orders were printed out by the pharmacy and the facility received them around 24th or 25th of each month. The nursing department would do " triple checks. " The checks included the orders on chart were checked against the MARs, then a MAR to MAR check would be done, and lastly, the third check was completed for any new orders that had been written and placed on the chart. Any new order would then be transcribed to the new MAR. Further interview revealed Administrative staff #1

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F 329	Continued From page 19 accepted the monthly order as the current order since it had been signed by the physician/nurse practioner. The signature meant the medications and treatments had been reviewed and were correct. The Administrative staff #1 revealed it was the intention of the nurse practioner to continue the Iron medication. An interview was conducted on 7/12/12 at 10:00 AM with the Nurse Practioner. This interview revealed she had signed the pharmacy recommendation to discontinue the Iron medication. During this interview, it was confirmed her intent was to stop the medication. Further interview revealed while doing the monthly medication reviews, she should have caught the error and discontinued the medication, before signing the orders. An interview was conducted on 7/12/12 1123AM with the consultant pharmacist. During this interview, the consultant stated could not remember if the recommendation that was signed by the nurse practioner was on the chart for June ' s monthly review. Further interview revealed not all recommendations are on the chart for the pharmacy review. This consultant reviewed the computer documentation of her report for June for the facility. The recommendations were " highlighted in yellow " which meant a response from the physician had not been received and placed on the chart, at the time of her review.	F 329		
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	F 371	F371 1.No resident was named in this citation. 2.Any resident can be affected by this practice. Therefore, the dietary department manager was provided an immediate in-service regarding food safety and sanitation by the consultant RD on 7/9/12.	

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F 371	Continued From page 20 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 1. properly store and date shredded cheese, remove expired food, a and dented can, and food spills on bags of frozen potatoes. and 2. ensure food preparation areas and service equipment were clean and dry by storing for use wet pans, plates with dried food, walk in freezer curtain with black substance, dirty storage carts for tray lids, dirty fan in use, inside ice cream freezer with brown debris and floor tiles in disrepair, yellow build up, and with black substance on the tile grout. The findings were: Observations on 7/9/11 from 9:30 AM to 10:15 AM revealed the following: 1. Located in the walk in refrigerator were: a. Mozzarella cheese without a date when it was opened, b. Cheddar cheese without the opened date and was open to air due to the foil wrapping being torn and c. one carton of cottage cheese with an expired date of 6/10/12. 2. Located in dry storage was one can of hunts ketchup which had a dent on one side of the can.	F 371	3.The Dietary staff was in-serviced by the CDM on 7/9/12-7/16/12 regarding storage, dating, removal of outdated foods as well as dented cans, cleanliness of packaging, wet pans, cleanliness of storage carts, fans, ice cream freezer and floor tiles & overall sanitation. Cleaning of flooring to be completed by 8/10/12. Plan to repair/replace broken floor tiles reviewed with team, and Resident Council President and completed by 8/10/12. Due to potential impact on residents regarding daily operations of dietary and food preparation the kitchen tile will be repaired/replaced by 8/10/12. 4.The CDM, kitchen manager or RD will conduct audits of the dietary department regarding storage, dating of foods, cleanliness of dishes, outdated foods, wet pans, dented cans, ice cream freezer, cleanliness of fans, twice per day for 12 weeks. Any issues found will result in staff counseling. RD and CDM will meet weekly times 12 weeks to discuss results of audits and any further needs related to food safety and sanitation. Results of these audits will be reviewed at the monthly QA meeting times 4 months by CDM.	8/10/12

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F 371	Continued From page 21 3. The ice cream freezer had brown dried debris underneath the cartons of ice cream 4. The clean dish area had a fan with dust build-up. The fan was on, and blowing on the clean silverware. 5. Inside the walk in freezer were: a. one box of cut potatoes in a total of three closed brown bags. All three bags had a yellow sticky liquid on top. And b. the inside of the door curtain strips had a black, wet substance on them. Interview on 7/9/12 at 9:30 AM with dietary manager #2 revealed there was a cleaning schedule for weekly and daily areas of the kitchen and equipment that were to be cleaned. The fan was not currently on the schedules. Interview on 7/9/12 at 10:15 AM with dietary manager #1 revealed something had spilled on the bags of potatoes and those were removed after making observations in the walk in freezer. Further interview revealed a replacement curtain was needed for the walk in freezer. Observations made on 7/11/12 at 8:27 AM revealed the following items were clean and stored ready for use: a. 1 sauce pan was stored with grease buildup. b. 16 of 20 bread pans were stacked wet c. 4 small serving pans were stacked wet d. 6 large serving pans were stacked wet. e. 3 medium serving pans were stacked wet Interview on 7/11/12 at 8:40 AM with the dietary	F 371		

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F 371	Continued From page 22 manager #1 revealed the pans should air dry, and he removed them. The sauce pan should be clean when stored, and was removed to be cleaned. Observations on 7/12/12 from 7:30 AM to 8:30 AM revealed the following: a. 3 PVC carts that store lids for the plated food had black substance on the connections of the pipes which ran down the length of the cart, across the top and across the bottom. The top of the cart had dried debris on top and one of the carts had a top covering that was cracked. b. 4 of 20 plates had dried food on the back of the plate and were stacked upside down, with the back of one plate against the front of the next plate. These were in the plate warmer and ready for use during the plating of breakfast food. c. The plates from the plate warmer were not used to plate the food. The serving line staff used plates that were stacked on the side of the serving line. When these plates were checked for cleanliness, they were found to be cool to touch. d. The floor tiles had yellow/brown substance underneath the large floor model mixer and adjacent ovens. The same type of yellow/brown substance was observed in the corners of the floor where the wall behind the stove and the adjacent wall meet. e. There were multiple floor tiles in the food prep areas that were broken or cracked.	F 371		

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F 371	Continued From page 23 f. The floor tiles across the room from the dish machine were broken and missing at the base board. At this same location, the grout between the tiles was black, and a black substance could be removed with a fingernail scrapping. Interview conducted on 7/12/12 at 8:15 AM with dietary manager #2 revealed the plates should be left on the warmer, and taken directly from the plate warmer to plate the food. This was the means of keeping the food warm. Further interview revealed the PVC carts needed to be cleaned or replaced with wire carts that could be cleaned thoroughly. Interview conducted on 7/13/12 at 10:00 AM with the administrator revealed it was her plan to replace all of the tiles in the kitchen. Further interview revealed she was aware of the problems with the floor tiles. A steam cleaning would be appropriate to assist with the grout cleaning.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425	**F425** 1.Resident 67 is receiving medications per the Physicians orders. 2.Any resident requiring medications can be affected by this practice. Therefore, the DON, SDC and Unit Managers audited MARS for unavailable medications 7/13/12. 3.The SDC provided in-services for staff nurses on 8/2/12 regarding procedure for obtaining medications for residents. 4.The DON, SDC and Unit Managers will audit the MARS 5 times per week for 8 weeks for missing/unavailable medications. The staff not providing medications will be immediately in-serviced and counseled. Results of the audits will be reviewed at the monthly QA meeting for 3 months by the DON.	8/10/12

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	345092	A. BUILDING _____ B. WING _____	C 07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 24 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the pharmacy failed to provide an anti-seizure medication to the facility for one (1) of ten (10) sampled residents for medication review. Resident #67 The findings were: Resident #67 was re-admitted to the facility on 2/16/11 with diagnoses of Convulsions, Alzheimer's, Diabetes type II, Atrial Fibrillation, Hypertension and Dysphagia. Review of the July 2012 physician ' s orders revealed Resident #67 received Phenobarbital liquid 22.5 milliliters (90 milligrams) every night for diagnosis of seizures. Review of the Medication Administration Records for the months of May revealed the Phenobarbital was not administered for the dates of May 23, 24, 25 and 26 at 10:00 PM. The front of the MAR documented the nurse ' s initials with a circle around the initials. This would indicate the medication was not given. Review of the back of the MAR revealed documentation explaining the	F 425		

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F 425	Continued From page 25 drug was not available from the pharmacy with the following quote: "Awaiting delivery from pharmacy". This explanation was given for each time the medication was not administered. Review of the June 2012 MAR revealed the Phenobarbital was not administered for the dates of the 6th and 7th at 10:00 PM. Again, the front of the MAR documented the nurse ' s initials with a circle around the initials. The back of the MAR revealed documentation explaining the drug was not given due to "awaiting delivery from pharmacy. The dose given on 6/6/12 was initialed as given. The documentation on the back of the MAR documented the dose as 12.5 milliters (ml). The explanation for only administering 12.5 ml revealed medication was not available to complete the dose of 22.5ml. During an interview with a pharmacy consultant on 7/12/12 at 1:23 AM revealed there were policy and procedures to ensure medications were provided to the residents. Further interview revealed a back-up pharmacy was available that was open 24 hours. During this interview it was explained the nurses would first look in the medication dispense (PIXIS) to see if it was available through the in-house back up. If the medication was not in the back-up system, the nurse would call pharmacy and request the medication to be delivered that night. Continued interview revealed the nurse could call the pharmacy and request the medication from the back up pharmacy. Interview with nurse #3 on 7/12/12 at 11:48 AM revealed medications that are not available can be called to a back up pharmacy if needed that	F 425		

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F 425	Continued From page 26 day. The back up pharmacy hours were 24 hours a day and medications would be delivered by the 24 hour pharmacy to the facility. Continued interview revealed, if the medication administration can wait, the pharmacy would be called, and it would come in the next delivery. The cut off time at the pharmacy for ordering meds was 2:00 PM. They can also access the in-house backup medications in the PIXIS system. Interview on 7/13/12 at 10:30 AM with Administrative nursing staff #1 revealed the expectation for obtaining medications would be to follow through the process. It was further explained a step in obtaining the Phenobarbital for Resident #67 would require a signed script from the physician before the pharmacy would send the medication. Further interview revealed two scripts would be necessary for the pharmacy to fill the medication order. During this interview, it was revealed the liquid Phenobarbital would not be in the back up dispenser PIXIS system. The interview concluded with the reason it was not delivered was do to pharmacy issues.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F428 1. Residents 32 and 136 are receiving their medications per the physician's orders. 2. Any resident requiring medications can be affected by this practice. Therefore, the DON, SDC will review the June and July monthly Pharmacists recommendations for accuracy of follow through	

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F 428	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review the facility failed to act upon the pharmacy recommendations for discontinuing drugs for a resident on Lorazepam and on Vitamin C for 2 of 10 residents (# 32 and # 136). Findings Include: 1. The record review dated 4/26/12, " Consultant Pharmacist Communication to Physician ", recommended to discontinue the lorazepam 0.5 mg q 8 hour as needed (prn) for anxiety, for lack of use. This document was signed by the physician on 5/29/12 agreeing to the recommendation. Observation and Review of record the Medication Administration Record (MAR) for the months of May and June and July of 2012 the lorazepam remained on the documents but there was no documentation that it had been given for either of these months. The lorazepam remained on the MAR currently being used on the hall for resident # 32, dated 7/1/12-7/31/12 7/12/121040am, Staff interview, the Director of Nursing (DON) reported getting the recommendations from pharmacist then delivers them to the perspective unit managers, the MD would review them and sign them as to whether he agreed or disagreed with the recommendation, then unit manager would either do a telephone	F 428	3. The SDC will conduct an in-service for licensed nurses on 8/2/12 regarding the procedure for follow through of the pharmacist's recommendations. 4. The DON and SDC will audit the next 2 months of recommendations for accuracy and timeliness of follow through of the orders. Results of the audits will be reviewed by the DON at the monthly QA meeting for the next 3 months.	8/10/12

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F 428	Continued From page 28 order or fax the recommendation to pharmacy, " It would be up to pharmacy to follow up on the order. " During a staff interview with the unit manager #1 on 7/12/12 1100am. She reported the Don gives the recommendations to the unit mangers by hand. She then stated she would give them to the physician to review and once the physician had reviewed the recommendation she would fax the recommendation to pharmacy and wait for a conformation that the fax was received, she would then sign the recommendation that it was faxed and discontinue it from the MAR. On 7/12/12 a staff interview, with the unit coordinator for clarification at 1205pm once the recommendation is received from the DON it is given to the Unit Manager number 1 and she reported there is only one unit Manager per hall. The orders are either placed in the physician ' s correspondence book on the 2nd floor or they are actually given to the physician if it is known what day he is coming, they are then handed to him and he either agrees or disagrees and gives the pharmacy recommendations back to the unit manager a that time. The other orders are brought back to the floor by medical records after the physician has signed to agree or disagree. Then the orders are written and then faxed to pharmacy, the unit manager signed the recommendation sheet indicating that she faxed the order. If the physician is not there on the day the recommendation is received, the unit manager keeps the recommendations in a folder waiting for the physician to view them.	F 428		

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F 428	Continued From page 29 On 7/12/12 at 315pm Staff interview with pharmacy, she reported that she rechecks the charts and looks for the consult sheet and if the order is complete it is documented on the consult drug regimen sheet. The Pharmacist reported she checked the charts on a monthly basis and if the order is not there it is relayed to the DON. Then another copy of the consult is sent to the doctor. The chart for June for resident #32 had been reviewed. The Pharmacist reported the most recent MAR for resident # 32 was not available when the chart was reviewed. Without looking at the MAR the follow up consult was not duplicated because there was nothing to show if the medication had been given within that month. And if the medication had been given in June her thoughts were that the medication was needed and if it showed the patient needed the medication she did not want to duplicate the recommendation. " At the time of the recommendation, the patient had not used the medication in a month. " Currently the order is still pending. And it is kept pending to make a note to look back at it. A review is normally made the last week of each month. When the chart was reviewed for the month of June the consult recommendation was not in the chart for resident # 32. A report is printed every month and the DON and the Administrator gets it with concerns from the pharmacy and the pharmacist stated one of the concerns is the response on the recommendations related to the length of time it takes the physician signing the consult and the placing the document in the chart. 7/12/12 351pm Unit manager when asked about	F 428		

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F 428	Continued From page 30 where her signature is on the consult she reports not being on this floor when this document was sent. 7/13/12 at 1222pm in an interview with DON and Administrator. The DON " There is a problem and this has been qa'd. " We have talked with the Dr. We will sit down with the Dr on a monthly basis and will go over the recommendations together. DON " the system is broke and we are working on it." 2. Resident #136 was re-admitted on 5-16-2012 from an acute care hospital with diagnoses of Cancer, Dementia and Depression. A record review revealed that a pharmacy drug regimen review was completed on 1-30-12 with recommendations to discontinue Vitamin C due to lack of a diagnosis to support its use. The recommendation was approved and signed by the attending physician on 1-31-2012. The order was not reviewed and discontinued from the Medication Administration Record until 3-1-2012. A review of the Medication Administration Record (MAR) revealed the resident had received the Vitamin C from the date the attending physician signed the order on 1-31-12 until it was discontinued by Nurse #1 on 3-1-12. During an interview on 7-12-12 with the pharmacy consultant, it was discovered that during the pharmacy regimen reviews, if the pharmacist recognized a recommendation had not been followed up on, it would be brought to the attention of the Director of Nursing (DON) and	F 428		

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F 428	Continued From page 31 another copy would be sent to the physician. If the consult is completed, the pharmacist records this on a consult drug regimen sheet. The pharmacy reported reviewing the resident charts on a monthly basis as required. During an interview with the DON, it was revealed that when she receives the consults from the pharmacy, she passes them to the unit managers so that the recommendations can be followed up on. She also revealed that there is a problem with the pharmacy communication system which is currently being addressed in the facility Quality Assurance program. This DON was not employed at this facility at the time this error occurred. During an interview with the residents attending physician on 7-12-12 at 5:15pm, he indicated his expectations for new orders or medication changes per pharmacy recommendations were two weeks. This would allow time for the physician or the staff to contact the family and allow the family to have dialogue about any changes. The physician also indicated that this gives him time to assess the resident before " Blindly accepting the pharmacist ' s recommendations. " An interview with Nurse #1 on 7-12-12 revealed that once Nurse #1 receives the orders they are placed in the physician correspondence book for the physician to review, or are given to him personally if he is making rounds in the facility that day. Once the orders are signed, they are placed in another chart rack and flagged so that they can be followed up on and faxed back to the pharmacy. Nurse #1 was unable to explain at the	F 428		

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F 428	Continued From page 32 time of this interview why this order was not completed in a timely manner.	F 428		
F 431 SS=D	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 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.	F 431	**F 431** 1.No resident was named in this citation. 2. Any resident receiving medications can be affected by this practice. Therefore, the DON, Unit Managers and SDC examined the medication carts and medication rooms and discarded any outdated medications. 7/13/12. 3. The SDC conducted an in-service on 8/1/12 and 8/2/12 for staff nurses regarding the need to date medications and procedures for discarding outdated medications. 4. The DON, SDC and Unit Managers will conduct audits 5 times per week for 8 weeks for outdated medications. Results of the audits will be reviewed at the monthly QA meeting for the next 3 months by the DON.	

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F 431	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews the facility failed to store medications properly in one (1) of four (4) medication rooms and one (1) of eight (8) medication carts. The findings were: 1. Observations of the medication room on the second floor on 7/11/12 at 10:45 AM revealed an opened multidose vial of Tubersol that was not dated when opened. The medication would be used for TB skin tests for the residents. Interview with nurse #4 during the observations revealed the medications in the cart were expired and should have been discarded. Further interview revealed the floor nurses on each shift should check for expired medications and discard them when found. Interview with nurse #4 on 7/11/12 at 10:45 AM revealed the medication in the refrigerator was expired and should have been discarded. Further interview revealed the floor nurses on each shift should check for expired medications and discard them when found. 2. During the observations of the 200 hall medication room, observations were made of one of the two medication carts for use on the 200 hall. Observations were made with nurse #4 in attendance. Findings inside the cart included the following: a. Eight floorstock Ducolax suppositories with an expired date of 3/4/12 b. Adviar Disku inhaler that had expired on 7/2/12	F 431		

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F 431	Continued From page 34 c. Floorstock Fiber Therapy that had expired on 5/12. Interview with nurse #4 on 7/11/12 at 10:45 AM revealed the medications in the cart were expired and should have been discarded. Further interview revealed the floor nurses on each shift should check for expired medications and discard them when found.	F 431		

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	345092	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/31/2012

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Tuesday 7/11/12 at approximately 10:45 AM onward the following was noted: 1) Dutch doors between the kitchen and dining room shall be permitted where they conform to 19.3.6.3. In addition, both the upper leaf and lower leaf shall be equipped with a latching device, and the meeting edges of the upper and lower leaves shall be equipped with an astragal, a rabbet, or a bevel. (NFPA 101 19.3.6.3.6) 42 CFR 483.70(a)	K 018	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. statements, facts, and conclusions that form the basis for the deficiency." K 018 Any resident residing in the facility can be affected by this practice therefore the Maintenance Director has installed the latching device to permit the meeting of the edges of upper/lower leaves of dutch door between kitchen and dining room. Maintenance Director completed audit of the facility doors to ensure appropriate closing of the doors by 8/17/12. Maintenance Director will audit facility doors quarterly to ensure appropriate closure is occurring. Results of these audits will be reviewed at QA meeting quarterly by Maintenance Director times 6 months. 8/17/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/17/12

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345092	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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
K 025	K 025 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Tuesday 7/11/12 at approximately 10:45 AM onward the following was noted: 1) The smoke wall on 4th and 5th floor have holes/penetrations that were was not sealed in order to maintain the required fire resistance rating of the smoke barrier. 42 CFR 483.70(a)	K025	K 025 The smoke wall on 4th and 5th floor have been sealed in relation to smoke barriers by 8/13/12. The Maintenance Director audited smoke walls on all floors to ensure all holes/penetrations are sealed appropriately by 8/17/12. To continue compliance any outside vendor/contractor needing to breach firewall integrity will be inspected by facility Maintenance Director to ensure continued fire resistance rating times 1 year. The Maintenance Director will maintain a record of any vendor/contractor activity and review/report at QA meeting monthly times 1 year. 8/17/12	
K 029	K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=F One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029		

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K 029	K 029 . Continued From page 2 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Tuesday 7/11/12 at approximately 10:45 AM onward the following was noted: 1) The dry storage room door is required to be non-vented self closing door. 2) The mechanical room on 1st floor is missing the latching hardware. 3) The soiled linen room corridor door on 1st floor laundry area did not close, latch and seal. 4) The linen closet located outside laundry is not self closing. 5) The ceiling in the chemical storage room has holes in the ceiling that have not been repaired to maintain the required rating of the area. 6) The ceiling in the dry storage room where the sprinkler pipe is mounted has holes that have not been repaired in order to maintain the requires rating of the area.	K029	The Dry storage room door was replaced by Maintenance Director on 8/13/12. The Mechanical room door on 1st floor had latching hardware replaced on 8/13/12 by Maintenance Director. The Soiled Linen Room Corridor door on 1st floor laundry was tightened to permit closure, latching and sealing on 8/10/12 by Maintenance Director. The linen closet outside of laundry had a self closing device installed on 8/10/12. The ceiling in the chemical storage room had repairs made to the ceiling to reestablish the required rating on 8/10/12 by the Maintenance Director. The ceiling in the dry storage room has been patched and repainted to maintain required rating by Maintenance Director on 8/10/12. Maintenance Director to complete audit using facility floor plan by 8/17/12 to ensure correct fire rating with regards to construction. Department Heads to be in-serviced by Maintenance Director on 8/17/12 regarding notification of maintenance needs related to construction needs IE: doors latching, and any holes in ceiling, to ensure work orders placed as appropriate. Maintenance Director will summarize and review work orders monthly at QA related to construction and life safety monthly times 6 months.	8/17/12
K 062 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Tuesday 7/11/12 at approximately 10:45 AM onward the following was noted: 1) Sprinkler heads have been installed in the smoke compartments throughout the facility were a mixture of quick response heads and standard fused heads are used. NFPA 101, 4.6.12.1 Every required sprinkler system shall be continuously maintained in proper operating condition. NFPA 13, 5-3.1.5.2 2) The sprinkler pressure gauges on the sprinkler riser system, "pressure gauge for fire protection service", the facility could not confirm the gauges had be celebrated within the past 5 years. 42 CFR 483.70(a)	K 062	K 062 The Maintenance Director has obtained a quote for replacement of sprinkler heads to assure consistent/compatible operating sprinkler heads and pressure gages. Quote was completed on 8/8/12 and work to be completed by 8/24/12 by SimplexGrinnell. Included in the sprinkler system inspection was an audit done by SimplexGrinnell to ensure standardization of sprinkler heads throughout facility on 8/7/12 with Maintenance Director. To ensure continued compliance with sprinkler system facility to continue with annual inspections with SimplexGrinnell. Maintenance Director will review any audits with QA quarterly times 6 months. 8/24/12	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Tuesday 7/11/12 at approximately 10:45 AM onward the following was noted: 1) In the laundry room there is an excessive amount of lint accumulated on the wall, ceiling and equipment that is a potential fire hazard. 2) The lint traps for the dryers have not be kept	K 130		

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K 130	Continued From page 4 clean and in good operating condition. 42 CFR 483.70(a)	K 130	K 130 The Maintenance Director cleaned and removed the accumulated lint on 7/31/12. The Maintenance Director assured lint traps are in good operating condition on 7/31/12. Maintenance Director audited dryer system equipment for any repairs needed 8/13/12. Environmental Supervisor in-serviced laundry personnel on process for cleaning, maintaining dryers system and procedure for removal of lint in dryer system 7/31/12. Environmental Supervisor and Maintenance Director to conduct daily rounds and audits to ensure compliance 5 times a week for 12 weeks and report findings at QA monthly times 6 months.	8/17/13