STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 observation during care and staff interview the facility failed to provide privacy for 1 of 4 (Resident #59) sampled residents. Resident #59 was re-admitted to the facility on	F 164	F164 Resident #59 is now provided privacy during incontinent care by closing the resident room door, pulling the privacy curtain and closing the window blinds. NA #2 was retrained on providing privacy during incontinent care by the Staff Development Coordinator on 1/30/13. Any resident receiving incontinent care had the potential to be affected by this alleged practice. Therefore, facility staff development coordinator has completed retraining with certified nursing assistants & licensed nurses related to privacy during incontinent care by closing of the resident room door, pulling the privacy curtain, and closing the window blinds on 1/29/13 and1/30/13	3/1/13

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

Administrator 2/21/13

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 164	Continued From page 1 4/14/2010. Her most recent Minimum Data Set (MDS) was coded as a annual assessment and dated 12/20/2012. The diagnoses listed on the MDS were history of old left frontal cerebrovascular accident (CVA), muscle weakness, and history of urinary tract infections (UTI). A record review revealed the facility had assessed Resident #59 on her most recent MDS as always incontinent of bowel and bladder, and that she was totally dependent on staff for toileting. The MDS noted that a trial of bladder training had not been attempted for either bowel or bladder upon admission or since bowel and bladder incontinence was noted in the facility. Incontinent care was observed at 1:00 PM on 1/30/13. The nursing assistant (NA) providing care closed the door and pulled the curtain between the residents but failed to close the open blind on the window that faced to half rounded driveway of the facility and the neighborhood street. As NA#2 provided incontinent care for Resident #59, the resident was left standing at her wheelchair with her bare buttocks facing the open window blinds. At 1:35 PM on 1/30/13, the NA was interviewed. NA #2 stated that she provides privacy for residents by closing the door and pulling the curtain in between residents. At 2:04 PM on 1/30/13, the Director of Nursing (DON) was interviewed. The DON stated that she expects all staff would close the door of the	F 164	The DON, ADON, SDC, administrative nurses and the floor nurses will monitor this practice to ensure that this correction is achieved and sustained. A monitoring tool has been developed to document observation on all shifts, 5 days per week and to report findings to the quality assurance committee each month for 3 months and then every 3 months thereafter for a period of 1 year.	

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F 164	Continued From page 2 resident's room, pull the curtain between residents, and close the blinds to provide privacy. At 2:30 PM on 1/30/13, the Administrator was interviewed. The Administrator stated that he expects staff to "close curtain, close the door, and I should say the blind too so yes close the blind ".	F 164		
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, record reviews, and resident and staff interviews, the facility failed to preserve resident dignity for 1 of 4 sampled residents assessed for urinary incontinence (Resident #59) by resident wearing an incontinent brief without providing an opportunity for toileting; and by a staff member failing to knock on the room door for 1 of 40 (Resident #70) sampled residents. Findings include: 1. Resident #59 was re-admitted to the facility on 4/14/10 with diagnoses including history of old left frontal cerebrovascular accident (stroke), muscle weakness, and history of UTIs (urinary tract infections). The most recent annual Minimum Data Set (MDS) dated 12/20/12 indicated the resident was cognitively intact for daily decision making skills. The MDS also indicated Resident	F 241	F241 Resident #59 has been reassessed for the bowel and bladder program and is currently participating in the program. Any resident incontinent of bowel & bladder could have been affected by this alleged practice. Therefore, a review of current resident medical records was completed & those identified as appropriate were placed in a bowel & bladder program. Staff Development Coordinator completed retraining for licensed nurses related to the timely completion of a bowel & bladder assessment for incontinent residents and follow up for residents identified as appropriate for a bowel & bladder program on 2/4/13.	3/1/13

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F 241	Continued From page 3 #59 was always incontinent of bowel and bladder and totally dependent on staff for toileting. The MDS noted a trial of toilet training had not been attempted for either bowel or bladder upon admission or since urinary/bowel incontinence was noted in the facility. During an interview with Resident #59 on 1/30/13 at 8:30 AM, the resident reported she did not use the bathroom facility in her room. The resident stated she wore a diaper as staff had indicated she would be at risk for falling in the bathroom with staff assist. Resident indicated she was cognitively aware of when she would need to use the toilet. When asked if she would prefer to use a toilet rather than the diaper, Resident #59 answered, "Yes." During a follow-up interview with Resident #59 on 1/30/13 at 12:50 PM, the resident was observed to be holding herself partially up from a sitting position in the wheel chair. When asked if she needed assistance, the resident said, " No, I have to do this when I have a bowel movement. " Resident #59 again indicated she would prefer to use the rest room for toileting if staff would help her do so. When asked how wearing a diaper made her feel, Resident #59 stated, "I just got use to it." During an interview with MDS Nurse #1 and MDS Nurse #2 on 1/30/13 at 2:08 PM, the MDS Nurses indicated Resident #59 had not been brought to their attention as needing a toileting assessment or initiation of a toileting program. If aware of the resident's desire to toilet, the nurses agreed they would refer her to the Restorative Nurse and talk with the staff about her needs. MDS Nurse #1	F 241	DON,ADON & Administrative nurses will review progress of residents participating in a bowel & bladder program weekly in the Standards of Care meeting. During the daily clinical meeting the DON, ADON ,& Administrative nurses will review the resident medical records of new admissions and re-admissions to verify a bowel & bladder assessment has been completed . A review of the progress of residents participating in the bowel and bladder program will occur weekly in the standard of care meeting weekly. The DON or the restorative nurse will create a resident progress report to present to the QA committee each month for 3 months and then quarterly thereafter for a period of 1 year.	

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F 241	Continued From page 4 stated, "If they say they can go, let them go to the bathroom." During an interview with the Restorative Nurse on 1/30/13 at 2:20 PM, the Restorative Nurse indicated she was not aware of the resident's desire to toilet. The Restorative Nurse stated her expectation would have been for staff to take the resident to the bathroom as requested for any resident that needed to use it. During an interview with the DON (Director of Nursing) on 1/30/13 at 2:29 PM, the DON indicated she had not been aware of the toileting status of Resident #59. The DON stated, "If I was made aware of that, we would have Restorative come in and assess her. If appropriate and safe we would toilet her per protocol and upon her request. We do assess this upon admission. Status may improve or decline and we would adjust the care plan accordingly." During a follow-up interview with the Restorative Nurse on 1/31/13 at 9:38 AM, it was indicated Resident #59 would start a 3-day toileting assessment on 2/2/13 and then progress to scheduled toileting. 2. At 08:33 AM on 1/31/13, observation of Resident #70 ' s room revealed a staff member entering the Resident's room without knocking, asking permission, or interacting with residents in the room. At 08:20 AM on 2/1/13, the staff member was interviewed. When asked about walking into a resident's room without knocking, the staff	F 241	Staff is now knocking on the door prior to entering the room of Resident #70 Identified staff member for Resident #70 was re-educated dignity and respect of individuality related to knocking on the resident's door prior to entering the room by Staff Development Coordinator on 01/29/13 Any resident's dignity and respect for individuality could have been affected by the alleged practice; therefore the staff have been re-educated on dignity and respect for individuality related to knocking on the door prior to entering a resident's room by the Staff Development Coordinator on 1/29/13 and 1/30/13	

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F 241	Continued From page 5 member admitted that the incident occurred and that the room was entered without knocking because he wasn't thinking and just wanted to cover up Resident #70 who "is often exposed and needing to be covered". At 8:43 AM on 2/1/13, the Administrator was interviewed. The Administrator stated that he would expect his employees to knock and announce themselves when entering a resident's room.	F 241	The DON, ADON, SDC, Administrative nurses and the floor nurses will monitor staff entering resident rooms related to knocking on the door prior to entering. A monitoring tool has been developed to document observation on all shifts 5 days per week. The DON, ADON and /or SDC will evaluate the audit findings weekly x 4 weeks, then monthly x 2 months, then quarterly thereafter for a period of 1 year; will implement retraining as necessary and present a progress report to the Quality Assurance committee each month for 3 months and then every 3 months thereafter for a period of 1 year.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to provide in room activities for 2 of 19 (Resident #70 and Resident #122) sampled residents. Findings include: 1. Record review showed Resident #70 was admitted to the facility on 6/30/2010 with multiple diagnoses. The Admission Minimum Data Set (MDS) dated 11/12/2012 indicated the resident was severely cognitively impaired and required extensive assistance of 1 with activities of daily living (ADL).	F 248		

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F 248	Continued From page 6 The MDS Preferences for Customary Routine and Activities dated 6/1/2012 indicated that the resident likes listening to music, keeping up with the news, spending time away from the nursing home, spending time outdoors, and participating in religious activities or practices. The Recreation Services Assessment dated 6/30/2010 stated that resident's religious preference is Baptist. The facility assessed resident #70 as able to hear, understand others and is able to answer yes or no questions or give short answers to questions but unable to hold a conversation. He was also assessed as being severely impaired in his decision making abilities. The assessment also stated the resident enjoys exercise, music, watching television, playing ball, being around other residents and attending spiritual/religious activities. The Patient Activities Progress note dated 8/16/12 indicated that Resident #70 was involved in music, exercise, and current events in the previous 90 days. The Patient Activities Progress note dated 11/12/12 indicated that Resident #70 was involved in current events, music, exercise, and brain games for the previous 90 days. The progress note also had documentation that Resident #70 continues to watch TV daily in his room and that his family visits often and is very supportive. An observation of Resident #70 on initial assessment at 10:00 AM on 1/28/13, found the resident in his room, and in bed with TV on. Other observations include:	F 248	F248 Resident #122 and resident #70 are being provided with activities designed to meet their needs in accordance with the comprehensive assessment their interest and their physical, mental and psychosocial wellbeing. Any resident identified for the need of in room activities could have been affected by this alleged practice. Therefore, the facility administrator provided re-training for the Activities Director related the provision of in room activities, including timely documentation of attendance on 2/4/13 The activity director completed a review of resident medical record to determine interest and needs for in room activities. The activities director as implemented an individual log sheet for each resident to document in room activities daily.	3/1/13

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F 248	Continued From page 7 1/30/13 at 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 1:00 PM, 3:00 PM, 4:00 PM. 1/31/13 at 8:00 AM, 10:00 AM, 11:00 AM, 2:00 PM, 3:00 PM. 2/1/13 at 8:00 AM, 9:00 AM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM During these observation times Resident #70 was in bed, in his room with the TV on. The Resident was observed out of his room only once for activities during the 5 days of survey. The resident attended exercise activity in the activities room on 2/1/13. Then returned to his room and was placed in bed. TV was on in Resident's room. During an interview on 1/31/2013 at 1:20 PM the Activities Director was asked if she had a log for the in room activities. A three ring binder was produced with the title In Room Activities. Inside the book were entries for the month of January 2013 that included watching TV and staff interaction with resident. The Activities Director was then asked if there were any more logs or reports from last year since their last survey. The Activities Director stated "No". The Activities Director indicated that the only in room activities where when the staff provided care. During an interview on 1/31/2013 at 1:27 PM the Administrator stated "I expect all residents to receive activities including in room activities". 2. Record review showed Resident #122 was	F 248	The facility Administrator will monitor in room activity documentation weekly x 6 weeks, then monthly thereafter to assure that individualized in room activities are occurring and being documented timely. The administrator will present a progress report to the Quality Assurance Committee each month for three months and then quarterly thereafter for a period of 1 year.	

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F 248	Continued From page 8 admitted on 6/15/2010 with a primary diagnosis of encephalopathy, lack of coordination, and swallowing problems. The Minimum Data Set (MDS) dated 10/31/2012 indicated the resident was severely cognitively impaired and totally dependant on staff for care. The MDS Preferences for Customary Routine and Activities dated 10/31/2012 indicated that Resident #122 prefers to listen to music, watch TV, and doing things with groups of people. As stated on the Recreation services assessment dated 6/5/10 stated Resident #122's religious preference is unknown but he enjoys attending facility spiritual/religious activities. The Resident also enjoys attending exercise, current events, Bingo, music, socials, and special events. Resident actively participates in group activities and also enjoys participating in activities as evidenced by resident laughing, smiling, and communicating with activities staff. The Resident was stated to be motivated and able to participate in structured group activities such as bingo, music, exercise with restorative, socials and special events. The recreation services assessment also stated that the Resident was motivated and able to participate in independent leisure activities such as watching TV, interacting with staff and other residents. The recreation services plan was as follows: Resident needs social interaction with others. Resident will be involved in three, thirty minute group activities weekly for the next 90 days to promote social interaction with others. Staff will invite and transport resident to and from Bingo, current events, exercise, with restorative, socials,	F 248		

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F 248	Continued From page 9	F 248		

spiritual/religious activities, and special events. Activities staff will assist resident to participate at highest level of involvement.

Review of Activities log located with the Activities Director:

Resident attended 3 activities for the month of January 2013, two activities attended for the month of December, no activities for the months of November, October, and November 2012.

In room Activities Log:

1/10/13: Staff visited with resident in his room. Resident was alert and responded to staffs voice. Resident with good spirit.

1/22/13: Staff spoke with Resident in his room. Resident was drifting in and out of sleep at that time.

No other in room activities had been done prior to January 2013.

The Resident was observed out of his room only once for activities during the 5 days of survey. The resident attended exercise activity in the activities room on 2/1/13. Then returned to his room and was placed in bed. TV was on in Resident's room.

During an interview on 1/31/2013 at 1:20 PM the Activities Director was asked if she had a log for the in room activities. A three ring binder was produced with the title In Room Activities. Inside the book were entries for the month of January

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F 248	Continued From page 10 2013 that included watching TV and staff interaction with resident. The Activities Director was then asked if there were any more logs or reports from last year since their last survey. The Activities Director stated "No". The Activities Director indicated that the only in room activities where when the staff provided care. During an interview on 1/31/2013 at 1:27 PM the Administrator stated "I expect all residents to receive activities including in room activities".	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	F280 Resident #173 and #124 care plans were reviewed and updated with current interventions related to fall prevention and CAN's and licensed nurses were retrained on current interventions by the staff developer 2/1/13.	3/1/13

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F 280	Continued From page 11 Based on observations, interviews and medical record review, the facility failed to develop and implement appropriate interventions to prevent repeated falls for 2 of 3 sampled residents reviewed for accidents/falls (Residents #173 and #124). The findings are: 1. Resident #173 was admitted to the facility on 8/31/12 with diagnoses including Alzheimers, cerebrovascular accident (stroke), and hemiplegia (paralysis of one side of the body). The initial admission Minimum Data Set (MDS) assessment dated 9/10/12 indicated the resident was moderately cognitively intact for daily decision making skills; he required limited assistance for transfers, locomotion and bed mobility. Bed rails were noted as not used. The fall history revealed 1 fall without injury occurred since admission. 11/16/12 quarterly MDS indicated resident was independent with bed mobility and noted bed rails were not used. The 11/16/12 quarterly MDS indicated 2 or more falls without injury had occurred since the previous assessment date. No rejection of care behaviors was noted. Care Area Assessments (CAAs) dated 9/10/12 triggered the areas of cognitive loss/dementia, communication, ADL function/rehabilitation potential, urinary incontinence, and falls. Resident #173's care plan dated 9/11/12 included a problem for falls characterized by a history of falls, multiple risk factors related to unsteady gait and decreased safety awareness. The goal for the resident was to remain free of injury as	F 280	Any resident with a care plan had the potential to be affected by this alleged practice. The Facility Care Plan Team has reviewed each resident's medical record and crossed-referenced their care plan with the CNA care guide to ensure that current interventions and updates, related to falls are in place. On 2/1/13 the DON , ADON, SDC & MDS nurses reviewed the facility care plan process to ensure interventions and updates related to falls will be communicated to the nursing staff timely. Nursing staff including CNA's were re-educated on Falls Prevention 2/1/13 by the Staff Development Coordinator.	

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F 280	Continued From page 12 evidenced by no falls or accidents through next review. Interventions to prevent falls included: bed in lowest position; ensure proper footwear while ambulating; bed alarm; chair alarm; and a scheduled toileting program. On 1/16/13 a revision was made to include 30-minute checks as a care plan approach. A review of Resident #173's medical record revealed multiple recent falls. A subsequent review of Fall Incident Reports for Resident #173 included the following reports: Fall Incident Report #1 with hand-written notes: 11/15/12 at 11:25 AM "Staff observed resident on floor next to bed, resident states he was trying to get back in bed and slipped on floor, no shoes on at time of fall, ROM (range of motion) WNL (within normal limits), no injuries." Additional comments and/or steps taken to prevent recurrence: "Ensure patient has proper footwear." No injury was sustained. Fall Incident Report #2 with hand-written notes: 11/23/12 at 6:30 AM: " Resident observed in Trendelenburg position (body on the bed, head on the floor), no injuries observed, denied pain. " Additional comments and/or steps taken to prevent recurrence: "Monitor restlessness, assist patient to wheelchair PRN (as needed)." No injury was sustained. Fall Incident Report #3 with hand-written notes: 1/4/13 at " PM " : " Resident was found sitting on floor in bedroom, no apparent injuries noted. " Additional comments and/or steps taken to prevent recurrence: "Offer rest breaks." No injury was sustained.	F 280	The DON will present a report to the Quality Assurance Committee monthly x 6 months, and then quarterly thereafter for 1 year relating the effectiveness of the falls interventions in place and the staff communication process for care plan updates and intervention changes.	

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Fall Incident Report #4 with hand-written notes: 1/5/13 at 7:25 PM: "Resident found sitting on floor on buttocks. No injury noted, states he was trying to sit on his wheelchair unassisted." Additional comments and/or steps taken to prevent recurrence: "Instructed to use call bell wait for assistance." Conclusion: "Resident continuously tries to get OOB (out of bed) on his own without assist, instructed to use his call bell for assistance." No injury was sustained.

Fall Incident Report #5 with hand-written notes: 1/10/13 at 8:20 AM: "Observed resident sitting on floor next to his bed, resident states he was trying to get to his wardrobe to get his clothes to put on, lost his balance and fell on floor." Additional comments and/or steps taken to prevent recurrence: (None). No injury was sustained.

Fall Incident Report #6 with hand-written notes: 1/12/13 at 8:30 PM: " Resident was found sitting on the floor in the front dining room. " Additional comments and/or steps taken to prevent recurrence: " Referred to therapy. " Conclusion: " Resident attempted to transfer again without assistance, pad alarm was not in place on bed for safety. " No injury was sustained.

Fall Incident Report #7 with hand-written notes: 1/13/13 at 1:50PM: "Called to room, found resident on floor next to bed, was trying to get back in bed, alarm did not sound, door was closed; no injuries noted." Additional comments and/or steps taken to prevent recurrence: " Monitoring per protocol; moved for closer observation." No injury was sustained.

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Fall Incident Report #8 with hand-written notes: 1/16/13 " PM ": " Patient was found on floor in bathroom." Additional comments and/or steps taken to prevent recurrence: "Continue monitoring and re-direction." No injury was sustained.

On 1/31/13 at 7:08 AM resident was observed in bed with full bed rails up on both sides Bed was not in the lowest position.

During an interview on 1/31/13 at 7:17 AM with Nurse #5 (3rd shift), the nurse stated resident's full bed rails were in the up position as resident "tries to get up."

Interview with MDS Nurse #2 was conducted on 1/31/13 at 8:36 AM. MDS Nurse indicated she was not aware of either the bed rails being used or the resident's bed being in a raised position.

During an interview on 1/31/13 at 8:54 AM with the ADON (Assistant Director of Nursing) and DON (Director of Nursing), the ADON and DON indicated they were not aware of either the bed rails being used for the resident or of the resident's bed being in a raised position. The DON stated the resident had recently been moved to the 100 hall so staff could watch him more closely. The DON did not believe resident had fallen since the hall transfer approximately 2 weeks ago.

On 1/31/13 at 9:20AM Maintenance was observed to be lowering Resident #173's bed.

Conducted an interview with NA #2 and NA #3 on

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F 280	Continued From page 15 2/1/13 at 2:44 PM regarding any measures taken to help prevent falls for Resident #173. NA #2 stated, "We assist him." NA #3 indicated a bed alarm and chair alarm are used to let staff know when Resident #173 is attempting to get up; Resident #173's bed has been lowered and the bed rails have been removed. An interview was conducted on 2/1/13 at 2:47 PM with Nurse #6. Nurse #6 indicated the nursing staff has developed a plan to monitor Resident #173 more closely and to go in more frequently to check on him. Nurse #6 stated, "We're doing every 30 minute checks." She also indicated a bed alarm and chair alarm are used for the resident so staff can hear him if he tries to get up. An interview was conducted on 2/1/13 at 2:54 PM with MDS Nurse #1 and MDS Nurse #2. The MDS nurses indicated they are informed of incident reports (including falls) by the morning 24-hour report. From the 24-hour report obtained in the Clinical Staff Meeting, information is relayed daily to the Department Head Meeting. The MDS nurses reported nursing staff on the hall are expected to put immediate interventions into place. The MDS nurses indicated resident care plans are usually inclusive, addressing topics such as medications and bowel/bladder issues. The nurses also indicated care plans are updated as changes happen and noted 30 minute checks were added to Resident #173's care plan on 1/16/13. The MDS nurses stated that when staff has exhausted everything for a resident such as Resident #173, a non-compliant problem area will be put in. Lastly, the MDS nurses reported that a Falls Meeting is conducted with the DON approximately once a week.	F 280		

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During an interview with the ADON (Assistant Director of Nursing) on 2/1/13 at 3:25 PM, the ADON discussed the process in deciding on interventions put into place for fall prevention. The ADON indicated that when a resident has a fall, it is discussed in the Clinical Meeting and a determination will be made as to what interventions are appropriate. From that point, the MDS Nurse(s) would pick it up, update the care plan, and let the staff know if there ' s a change. The ADON indicated she would expect "a quick turn around" as to when an intervention is put on the care plan. The ADON also stated, " It is our hope it (the intervention) goes on the care plan after that meeting." The ADON noted a Falls Meeting is conducted weekly and if an intervention hasn ' t worked, it will be re-evaluated. After it was reported there has not been an intervention noted/changed after each fall, the ADON stated, "My understanding is that after we determined the interventions that they would be put on the care plan."

2. Resident #124 was admitted to the facility on 3/22/2012. Her diagnosis included severe sepsis secondary to urinary tract infection, acute renal failure, hyperkalemia, altered mental status, type 2 diabetes, heart failure with preserved ejection fraction, atrial fibrillation, dementia and hypertension.

The care plan dated 4/02/12 included a problem listed as Risk for falls characterized by history of falls, multiple risk factors related to unstable health condition. The goal was: Resident will remain free of injury as evidenced by no falls or accidents through next review. Intervention/approaches were listed as:

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F 280	Continued From page 17 Monitor for signs and symptoms of dizziness and encourage resident to report episodes of dizziness to staff. Assist as necessary Analyze previous resident falls to determine whether pattern or trend can be addressed Assist during transfer and mobility Encourage resident to take rest periods as needed when ambulating. Evaluate effectiveness and side effects of psychotropic drugs for possible decrease in dosage elimination of drug Monitor and intervene for factors causing falls i.e. bowel/bladder needs, mobility transfers etc. Monitor medications for potential side effects that may increase risk for falls, i.e., blurred vision, orthostatic hypotension, dizziness and provide diversional activities. The care plan also indicated a referral would be made to therapy and that she was started in the restorative ambulation program on 5/18/12. Resident #124's care plan was reviewed on 5/8/12, 6/29/12, 12/13/12 with no additional interventions or updates related to her falls. A review of Resident #124's fall history revealed 4 falls on the dates 10/31/12, 11/4/12, 12/02/12 and 1/26/13. An interview was conducted on 2/01/13 at 11:15 AM with the Director of Nursing (DON). The DON indicated she expects the care plan to be revised and updated with the new information at the time the MDS nurses are notified.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

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F 282	Continued From page 18 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 record review, observation, and staff interview the facility failed to follow the care plan for a resident needing sensory stimulation and socialization with others for 1 of 2 (Resident #70) sampled residents. Findings Include: Record review showed Resident #70 was admitted to the facility on 6/30/2010. The Admission Minimum Data Set (MDS) dated 11/12/2012 indicated the resident was severely cognitively impaired and required extensive assistance of 1 with activities of daily living (ADL). The MDS Preferences for Customary Routine and Activities dated 6/1/2012 indicated that the resident likes listening to music, keeping up with the news, spending time away from the nursing home, spending time outdoors, and participating in religious activities or practices. The Recreation Services Assessment dated 6/30/2010 stated that resident's religious preference is Baptist. The facility assessed resident #70 as able to hear, understand others and is able to answer yes or no questions or give short answers to questions but unable to hold a conversation. He was also assessed as being severely impaired in his decision making abilities.	F 282	F282 Resident #70 is being provided with activities designed to meet his needs in accordance with his care plan relating to needs for sensory stimulation and socialization with others. The facility Administrator provided re-training for the Activity Director related to following the care plan for a resident needing sensory stimulation and socialization with others on 2/4/13. The activity director has completed a review of the medical records/care plan for resident #70 to determine his likes and dislikes and the need for activities that provide sensory stimulation and socialization with others. This was completed on 2/4/13. Any resident identified in the care plan as in need of activities including sensory stimulation and socialization with others could have been affected by	3/1/13

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F 282	Continued From page 19 The assessment also stated the resident enjoys exercise, music, watching television, playing ball, being around other residents and attending spiritual/religious activities. Upon review of the activities log located with the Activities Director, Resident #70 attended 6 activities for the month of August 2012, no activities for the month of September, 2 activities for the month of October, no activities for the month of November, 5 activities for the month of December, and 1 activity for the month of January 2013. The care plan dated 11/1/2012 stated "Resident needs sensory stimulation and socialization with others" with planned implementation of "resident will be involved in three activities per week through next review to provide sensory stimulation and socialization ". The Resident was observed out of his room only once for activities during the 5 days of survey. The resident attended exercise activity in the activities room on 2/1/13. Then returned to his room and was placed in bed in a supine position. TV was on in Resident's room. During an interview on 1/31/2013 at 1:20 PM the Activities Director was asked if she had a log for the in room activities. A three ring binder was produced with the title In Room Activities. Inside the book were entries for the month of January 2013 that included watching TV and staff interaction with resident. The Activities Director was then asked if there were any more logs or reports from last year since their last survey. The Activities Director stated "No". The Activities	F 282	this alleged practice. Therefore, the facility administrator provided re-training for the Activities Director related to the planning, provision and documentation of individualized activity needs assessed in the resident care plan for in or out of room activities including sensory stimulation and socialization with others. The activity director has completed a review of the medical records/ care plans for residents to determine his/her likes and dislikes and individual needs for activities as assessed in the care plan including sensory stimulation and socialization with others. The activities director will maintain an individual log sheet for each resident to document activities daily. This was completed on 2/4/13.	

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F 282	Continued From page 20 Director indicated that the only in room activities where when the staff provided care. During an interview on 1/31/2013 at 1:27 PM the Administrator stated "I expect all residents to receive activities including in room activities" .	F 282	The facility Administrator will monitor activity documentation weekly x 6 weeks, and then monthly thereafter to assure that the Activity Director is planning activities according to the individual needs assessed in the care plan including sensory stimulation and socialization with others. The administrator will present a progress report to the Quality Assurance Committee each month for three months and then quarterly thereafter for a period of 1 year.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to provide services to restore resident ' s continence as much as possible for 1 of 4 sampled residents assessed for urinary incontinence (Resident #59). Findings include: Resident #59 was re-admitted to the facility on 4/14/10 with diagnoses including history of old left frontal cerebrovascular accident (stroke), muscle weakness, and history of UTIs (urinary tract infections). The most recent annual Minimum Data Set (MDS) dated 12/20/12 indicated the resident was cognitively intact for daily decision	F 315		

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F 315	Continued From page 21 making skills. The MDS also indicated Resident #59 was always incontinent of bowel and bladder and totally dependent on staff for toileting. The MDS noted a trial of toilet training had not been attempted for either bowel or bladder upon admission or since urinary/bowel incontinence was noted in the facility. During an interview with Resident #59 on 1/30/13 at 8:30 AM, the resident reported she did not use the bathroom facility in her room. The resident stated she wore a diaper as staff had indicated she would be at risk for falling in the bathroom with staff assist. Resident indicated she was cognitively aware of when she would need to use the toilet. When asked if she would prefer to use a toilet rather than the diaper, Resident #59 answered, "Yes." During a follow-up interview with Resident #59 on 1/30/13 at 12:50 PM, the resident was observed to be holding herself partially up from a sitting position in the wheel chair. When asked if she needed assistance, the resident said, "No, I have to do this when I have a bowel movement." Resident #59 again indicated she would prefer to use the rest room for toileting if staff would help her do so. The resident stated she would probably only eat soup for lunch so she could eat quickly and nurses would have time to change her " diaper "before going to Bingo this afternoon. When asked how wearing a diaper made her feel, Resident #59 stated, " I just got use to it." During an interview with MDS Nurse #1 and MDS Nurse #2 on 1/30/13 at 2:08 PM, the process of identifying candidates for a toileting program was	F 315	F315 Resident #59 has been reassessed for the bowel and bladder program and is currently participating in the program. Any resident incontinent of bowel & bladder could have been affected by this alleged practice. Therefore, a review of current resident medical records was completed & those identified as appropriate were placed in a bowel & bladder program. Staff Development Coordinator completed retraining for licensed nurses related to the timely completion of a bowel & bladder assessment for incontinent residents and follow up for residents identified as appropriate for a bowel & bladder program on 2/4/13.	3/1/13

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F 315	Continued From page 22 outlined. It was noted that the Restorative Nurse identified and assessed candidates for a toileting program. The MDS Nurses indicated staff can refer a resident to the Restorative Nurse if there is a question about whether or not the resident is a candidate. The MDS Nurses indicated Resident #59 had not been brought to their attention as needing a toileting assessment or initiation of a toileting program. If aware of the resident ' s desire to toilet, the nurses agreed they would refer her to the Restorative Nurse and talk with the staff about her needs. MDS Nurse #1 stated, " If they say they can go, let them go to the bathroom. " During an interview with the Restorative Nurse on 1/30/13 at 2:20 PM, it was indicated that residents are identified for appropriate scheduled toileting based upon the admission bowel and bladder assessment form, nursing notes and patient history. Additionally, residents who may benefit from a toileting program may be brought to her attention by any nursing staff, therapy staff, and/or the MDS nurses. The Restorative Nurse indicated she was not aware of the resident ' s desire to toilet. The Restorative Nurse stated her expectation would have been for staff to take the resident to the bathroom as requested for any resident that needed to use it. During an interview with the DON (Director of Nursing) on 1/30/13 at 2:29 PM, the DON indicated she had not been aware of the toileting status of Resident #59. The DON stated, "If I was made aware of that, we would have Restorative come in and assess her. If appropriate and safe we would toilet her per protocol and upon her request. We do assess	F 315	DON,ADON & Administrative nurses will review progress of residents participating in a bowel & bladder program weekly in the Standards of Care meeting. During the daily clinical meeting the DON, ADON ,& Administrative nurses will review the resident medical records of new admissions and re-admissions to verify a bowel & bladder assessment has been completed . A review of the progress of residents participating in the bowel and bladder program will occur weekly in the standard of care meeting weekly. The DON or the restorative nurse will create a resident progress report to present to the QA committee each month for 3 months and then quarterly thereafter for a period of 1 year.	

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F 315	Continued From page 23 this upon admission. Status may improve or decline and we would adjust the care plan accordingly." During a follow-up interview with the Restorative Nurse on 1/31/13 at 9:38 AM, it was indicated Resident #59 would start a 3-day toileting assessment on 2/2/13 and then progress to scheduled toileting. On 1/31/13 at 11:40 AM, observed a bedside commode in Resident #59 ' s room. When Resident #59 was asked if this bedside commode was hers, she stated, "Yes, now I don't have to stand up while they clean my behind. I get weak doing that all the time." Resident stated having the bedside commode, "makes me very happy."	F 315	F323 Resident #173 care plan was reviewed and updated with current interventions related to fall prevention and CNA's and licensed nurses were retrained on current interventions the staff developer 2/1/13. Any resident with a care plan had the potential to be affected by this alleged practice. The Facility Care Plan Team has reviewed each resident's medical record and crossed-referenced their care plan with the CNA care guide to ensure that current interventions and updates, related to falls are in place. On 2/1/13 the DON, ADON, SDC & MDS nurses reviewed the facility care plan process to ensure interventions and updates related to falls will be communicated to the nursing staff timely.	3/1/13
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to put interventions in place to prevent recurrent falls for 1 of 3 residents (resident # 173) reviewed for falls; and hand rails on 1 of 5 resident corridors/halls (hallway between 300 and 400 halls) were chipped and had exposed rough splintered wood.	F 323		

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F 323	Continued From page 24 Findings include: 1. Resident #173 was admitted to the facility on 8/31/12 with diagnoses including Alzheimers, cerebrovascular accident (stroke), and hemiplegia (paralysis of one side of the body). The initial admission Minimum Data Set (MDS) assessment dated 9/10/12 indicated the resident was moderately cognitively intact for daily decision making skills; he required limited assistance for transfers, locomotion and bed mobility. Bed rails were noted as not used. The fall history revealed 1 fall without injury occurred since admission. 11/16/12 quarterly MDS indicated resident was independent with bed mobility and noted bed rails were not used. The 11/16/12 quarterly MDS indicated 2 or more falls without injury had occurred since the previous assessment date. No rejection of care behaviors was noted. Care Area Assessments (CAAs) dated 9/10/12 triggered the areas of cognitive loss/dementia, communication, ADL function/rehabilitation potential, urinary incontinence, and falls. Resident #173's care plan dated 9/11/12 included a problem for falls characterized by a history of falls, multiple risk factors related to unsteady gait and decreased safety awareness. The goal for the resident was to remain free of injury as evidenced by no falls or accidents through next review. Interventions to prevent falls included: bed in lowest position; ensure proper footwear while ambulating; bed alarm; chair alarm; and a scheduled toileting program. On 1/16/13 a revision was made to include 30-minute checks	F 323	Nursing staff including CNA's was re-educated on Falls Prevention 2/1/13 by the Staff Development Coordinator. The DON will present a report to the Quality Assurance Committee monthly x 6 months, and then quarterly thereafter for 1 year relating the effectiveness of the falls interventions in place and the staff communication process for care plan updates and intervention changes. The hand rail between the 300 and the 400 hall has been repaired. 2/1/13 Any handrail in the facility has the potential to be loose. Therefore, the maintenance director completed an audit of handrails throughout the facility to ensure they were tightened and any screw holes were filled with wood filler as needed.	

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F 323	Continued From page 25 as a care plan approach. A review of Resident #173's medical record revealed multiple recent falls. A subsequent review of Fall Incident Reports for Resident #173 included the following reports: Fall Incident Report #1 with hand-written notes: 11/15/12 at 11:25 AM " Staff observed resident on floor next to bed, resident states he was trying to get back in bed and slipped on floor, no shoes on at time of fall, ROM (range of motion) WNL (within normal limits), no injuries. "Additional comments and/or steps taken to prevent recurrence: " Ensure patient has proper footwear." No injury was sustained. Fall Incident Report #2 with hand-written notes: 11/23/12 at 6:30 AM: " Resident observed in Trendelenburg position (body on the bed, head on the floor), no injuries observed, denied pain. " Additional comments and/or steps taken to prevent recurrence: "Monitor restlessness, assist patient to wheelchair PRN (as needed)." No injury was sustained. Fall Incident Report #3 with hand-written notes: 1/4/13 at "PM" : "Resident was found sitting on floor in bedroom, no apparent injuries noted." Additional comments and/or steps taken to prevent recurrence: " Offer rest breaks. " No injury was sustained. Fall Incident Report #4 with hand-written notes: 1/5/13 at 7:25 PM: " Resident found sitting on floor on buttocks. No injury noted, states he was trying to sit on his wheelchair unassisted." Additional comments and/or steps taken to	F 323	The maintenance director was in serviced by the administrator on 2/1/13 concerning preventive maintenance and the use of the handrail log and what to look for during daily rounds. Each week the maintenance director and or the administrator will check each hand rail to assure that they are still tight and have no splinters. A form has been developed to document these rounds and the results of anything in need of repair. The administrator will also check for the security of the rails each day as he makes rounds throughout the facility. A summary of monitoring efforts will be prepared by the maintenance director and presented to the quality assurance committee each month for 3 months and then quarterly thereafter for a period of 1 year.	

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prevent recurrence: " Instructed to use call bell wait for assistance." Conclusion: "Resident continuously tries to get OOB (out of bed) on his own without assist, instructed to use his call bell for assistance." No injury was sustained.

Fall Incident Report #5 with hand-written notes: 1/10/13 at 8:20 AM: "Observed resident sitting on floor next to his bed, resident states he was trying to get to his wardrobe to get his clothes to put on, lost his balance and fell on floor." Additional comments and/or steps taken to prevent recurrence: (None). No injury was sustained.

Fall Incident Report #6 with hand-written notes: 1/12/13 at 8:30 PM: " Resident was found sitting on the floor in the front dining room. " Additional comments and/or steps taken to prevent recurrence: " Referred to therapy." Conclusion: "Resident attempted to transfer again without assistance, pad alarm was not in place on bed for safety." No injury was sustained.

Fall Incident Report #7 with hand-written notes: 1/13/13 at 1:50PM: "Called to room, found resident on floor next to bed, was trying to get back in bed, alarm did not sound, door was closed; no injuries noted." Additional comments and/or steps taken to prevent recurrence: " Monitoring per protocol; moved for closer observation. " No injury was sustained.

Fall Incident Report #8 with hand-written notes: 1/16/13 " PM": "Patient was found on floor in bathroom." Additional comments and/or steps taken to prevent recurrence: "Continue monitoring and re-direction." No injury was

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F 323	Continued From page 27 sustained. On 1/31/13 at 7:08 AM resident was observed in bed with full bed rails up on both sides. Bed was not in the lowest position. During an interview on 1/31/13 at 7:17 AM with Nurse #5 (3rd shift), the nurse stated resident's full bed rails were in the up position as resident "tries to get up." Interview with MDS Nurse #2 was conducted on 1/31/13 at 8:36 AM. MDS Nurse indicated she was not aware of either the bed rails being used or the resident's bed being in a raised position. During an interview on 1/31/13 at 8:54 AM with the ADON (Assistant Director of Nursing) and DON (Director of Nursing), the ADON and DON indicated they were not aware of either the bed rails being used for the resident or of the resident ' s bed being in a raised position. The DON stated the resident had recently been moved to the 100 hall so staff could watch him more closely. The DON did not believe resident had fallen since the hall transfer approximately 2 weeks ago. On 1/31/13 at 9:20 AM observed Resident #173's bed being lowered to the lowest position. On 1/31/13 at 1:32 PM observed Resident #173's bed rails had been removed from the bed. Conducted interview with NA #2 and NA #3 on 2/1/13 at 2:44 PM regarding any measures taken to help prevent falls for Resident #173. NA #2 stated, " We assist him. " NA #3 indicated	F 323		

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F 323	Continued From page 28 Resident #173 does not have a bed rail any longer; a bed alarm and chair alarm are used to let staff know he's getting up; and the bed has been lowered. An interview was conducted on 2/1/13 at 2:47 PM with Nurse #6. Nurse #6 indicated the nursing staff has developed a plan to monitor Resident #173 more closely and to go in more frequently to check on him. Nurse #6 stated, "We're doing every 30 minute checks. She also indicated a bed alarm and chair alarm are used for the resident so staff can hear him if he tries to get up. An interview was conducted on 2/1/13 at 2:54 PM with MDS Nurse #1 and MDS Nurse #2. The MDS nurses indicated they are informed of incident reports (including falls) by the morning 24-hour report. From the 24-hour report obtained in the Clinical Staff Meeting, information is relayed daily to the Department Head Meeting. The MDS nurses reported nursing staff on the hall are expected to put immediate interventions into place. The MDS nurses indicated resident care plans are usually inclusive, addressing topics such as medications and bowel/bladder issues. The nurses also indicated care plans are updated as changes happen and noted 30 minute checks were added to Resident #173's care plan on 1/16/13. The MDS nurses stated that when staff has exhausted everything for a resident such as Resident #173, a non-compliant problem area will be put in. Lastly, the MDS nurses reported that a Falls Meeting is conducted with the DON approximately once a week. During an interview with the ADON (Assistant Director of Nursing) on 2/1/13 at 3:25 PM, the	F 323		

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ADON discussed the process in deciding on interventions put into place for fall prevention. The ADON indicated that when a resident has a fall, it is discussed in the Clinical Meeting and a determination will be made as to what interventions are appropriate. From that point, the MDS Nurse(s) would pick it up, update the care plan, and let the staff know if there ' s a change. The ADON indicated she would expect "a quick turn around" as to when an intervention is put on the care plan. The ADON also stated, "It is our hope it (the intervention) goes on the care plan after that meeting." The ADON noted a Falls Meeting is conducted weekly and if an intervention hasn't worked, it will be re-evaluated. After it was reported there has not been an intervention noted/changed after each fall, the ADON stated, " My understanding is that after we determined the interventions that they would be put on the care plan."

2) On 2/1/13 at 3:30 PM an Environmental Observation of the facility was conducted with Maintenance and the Director of Housekeeping. During the observation it was revealed the hand rail in the hallway between 300 and 400 halls had multiple areas with chipped wood that were splintered. The Maintenance Director was shown the damaged area on the hand rail.

An interview with the facility's Maintenance Director was conducted on 2/1/13 at 3:30 PM concerning the chipped and splintered wood on the handrail hallway between 300 and 400 halls. The Maintenance Director was shown the damaged area on the hand rail. The Maintenance Director indicated he had not previously been aware of any maintenance

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F 323	Continued From page 30 issues/problems with the 300-400 hallway hand rails.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 3 medication errors out of 51 opportunities, resulting in a medication error rate of 5.88%, for 3 of 19 residents observed during medication pass (Residents #4, #125, and #34). The findings are: 1. Resident #4 was admitted to the facility on 3/31/09 with diagnoses including HTN (hypertension) and anemia. A review of the January 2013 Physician's Monthly orders included an order for Tylenol 325mg caplets with directions to take 2 tablets (650 mg) by mouth every 4 hours as needed for pain. A review of the January 2013 Medication Administration Record (MAR) indicated a physician ' s order for Tylenol 325 mg caplets with directions to take 2 tablets (650 mg) by mouth every 4 hours as needed for pain. On 1/31/13 at 5:39 AM, Nurse #2 was observed preparing two floor stock medications for	F 332	F332 Residents #4, #125 and #34 are receiving their medications as ordered by their physician. Nurse #2 & #7 were re-trained on proper medication administration which included the "7 rights" of medication administration... This training was conducted by the Staff Development Coordinator on 1/31/13. Any resident that has medications administered had the potential to be affected by this alleged practice; therefore, medication administration observation will be conducted. Observations will be completed 3x weekly on various shifts for 4 weeks until current staff is observed. DON, ADON, SDC and administrative nurses will conducted the observation and	3/1/13

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F 332	Continued From page 31 administration to Resident #4. The nurse measured 10ml of Q-Tussin DM into a medication cup and indicated the second medication was Tylenol 325 mg and would be taken from the floor stock. Nurse #2 then took 2 tablets from a floor stock bottle and put them into a medication cup for administration (stock bottle was observed to be labeled as 325mg aspirin not 325mg Tylenol). As Nurse #2 left the med cart with the two medication cups and headed into the resident ' s room, requested the nurse re-state what medication was about to be given to Resident #4. Nurse #2 stated the tablets were Tylenol and she was going to give the PRN (as needed) dose to the resident. Upon request, Nurse #2 checked the identity of the tablets against the MAR and the stock bottle it was taken from. Nurse #2 then confirmed the identity of the tablets as aspirin 325mg (not Tylenol 325 mg). Nurse #2 discovered the med cart was out of Tylenol 325mg tablets and obtained a new floor stock bottle of Tylenol from the stock room for use on the medication cart. During an interview with the Director of Nursing (DON) on 2/1/13 at 11:40 AM, the DON was asked what procedure is used to ensure the appropriate stock medication is administered to a resident. The DON indicated her expectation was for a nurse to check the bottle against the MAR (Medication Administration Record) to be sure that it ' s the same thing and the right medication, dose, and form. 2. Review of the medical record revealed Resident #125 was admitted to the facility on 12/17/12 with diagnoses including rhonchi (a respiratory sound caused by air passing through	F 332	complete the "med pass observation" audit tool. Any nurse having a medication error will attend re-training and a medication administration observation will be repeated; if error occurs on repeat observation, the nurse will attend a re-orientation class on medication administration including written testing and practical of 3 error free medication administration observations before being allowed to administered medication independently. Licensed nurses were re-trained on medication administration which included the "7 Rights" of medication administration. The training was conducted by the Staff Development Coordinator on 2/4/13.	

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F 332	Continued From page 32 bronchi that are narrowed by inflammation, spasm, or the presence of mucus). The January Physician Orders indicated Resident #125 ' s nebulizer treatments were scheduled to be administered at 0900 (9:00 AM); 1300 (1:00 PM); 1700 (5:00 PM); 2100 (9:00 PM); 0100 (1:00 AM); and 0500 (5:00 AM). On 1/31/13 at 6:38 AM, Nurse #2 was observed obtaining a vial of generic DuoNeb (ipratropium and albuterol) from the medication cart for Resident #125. Resident #125 was suctioned due to respiratory secretions (which were audible) prior to initiation of the nebulizer treatment. Nurse #2 began the nebulizer treatment with generic DuoNeb at 6:45 AM. Based on the January Physician Orders, the observed nebulizer treatment was given 1 hour and 45 minutes after the scheduled administration time. 3. The record review showed Resident #34 was admitted to the facility on 6/21/2012 with diagnosis including hypertension, hyperlipidemia, diabetes, chronic obstructive pulmonary disease, and end stage renal disease requiring dialysis. On 1/31/13 at 06:11 AM, nurse #7 was observed giving medications to Resident #34. The medication that was given was Liquid tears polyvinyl alcohol 1.4% one drop in each eye. The record review showed a Doctor ' s order written as Liquid tears instill 2 drops into each eye four times a day.	F 332	The DON & ADON will monitor the results of the medication administration observations, as well as, re-training. The DON will report the facility medication error rate to the Quality Assurance Committee monthly x 6 months, then quarterly thereafter for a period of one year	

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F 332	Continued From page 33 On 1/31/13 at 2:30 PM the Director of Nursing (DON) was interviewed. The DON indicated that she expected medications to be given as ordered by the Doctor.	F 332		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility did not date food items in 1 of 5 resident hall nourishment pantries (100 hall); and did not maintain refrigerator temperatures in 2 of 5 resident hall nourishment pantries (200 hall and 400 hall). Findings include: On 2/1/13 from 3:30 PM to 5:30 PM an Environmental Observation of the facility was conducted with the Maintenance Director and Director of Housekeeping. Observations were made of each nourishment pantry. An observation of the 200 hall nourishment pantry on 2/1/13 at 3:40 PM revealed the refrigerator did not have a thermometer.	F 371	F371 No residents were named in this deficiency. The undated food items were discarded. 1/31/13 an audit was completed and all unlabeled and undated food items were discarded. An audit was completed on facility refrigerators and any unlabeled, undated, or past 3 day storage limit items were discarded. The facility Administrator in-serviced the housekeeping supervisor on 2/4/13. Review of the guidelines for food storage in the nourishment refrigerators was completed. The Housekeeping Director will monitor nourishment room refrigerators daily ensuring that all items are properly stored and dated.	3/1/13

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F 371	Continued From page 34 An observation of the 100 hall nourishment pantry on 2/1/13 at 3:55 PM revealed one bottle of ProMod (a nutritional supplement) and one bottle of ProStat (a nutritional supplement) were being stored (opened and not dated). An observation of the 400 hall nourishment pantry on 2/1/13 at 4:15 PM revealed the current refrigerator temperature was 28oF. The last temperature recorded on the refrigerator temp log was dated 10/24/12. An interview with the facility's Maintenance Director and Director of Housekeeping was conducted on 2/1/13 at 4:20 PM concerning the condition and contents of the resident hall nourishment pantries. The Maintenance Director and Director of Housekeeping indicated that neither were sure if the items belonged to the residents or the staff and that all nourishment rooms would be cleaned out and any additional items would be labeled and dated appropriately. The maintenance director also indicated thermometers should be in the refrigerators and the temperatures should be recorded daily. He further added the facility has a work order system in place for the staff to notify him of any maintenance issues and that he had not received anything regarding the nourishment rooms.	F 371	Staff Development Coordinator and Housekeeping Director have in serviced staff on proper storage and dating of item placed in the refrigerators. 2/4/13 The housekeeping director will collect the results of the monitoring efforts and present them to the quality assurance committee each month for 3 month and then quarterly thereafter for a period of 1 year. The nourishment refrigerators have had new thermometers inserted on 2/4/13 and a temperature log is being maintained. **The 3rd shift CNA Preceptors will check the refrigerators and record the temperature in the log each night**	
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	F 431		

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F 431	Continued From page 35 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to securely store medication in 2 of 5 medication carts observed during observations of medication administration and storage; failed to ensure all medications were labeled with an expiration date in 1 of 5 medication store rooms (500 hall); and failed to	F 431	The housekeeping director will collect the temperature logs for review and generate a nourishment room report based on his weekly rounds to present at the Quality Assurance Committee meeting monthly x 3, then quarterly thereafter for a period of one year. F431 No residents were named in this deficiency. The open Tuberculin PPD vial was discarded on 1/31/13.Medication carts were secured on 1/31/13 and the Advair was discarded. Nursing staff were in serviced by the Staff Development Coordinator on proper medication administration and procedures regarding responsibility for checking expiration dates on medication	3/1/13

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F 431	Continued From page 36 label and discard expired medications as specified by the drug manufacturer in 1 of 5 medication carts (400 hall). Findings included: 1. On 1/31/13 at 5:20 AM, observed an unattended medication cart in the 400 Hall. The medication cart was unlocked and out of the nurse ' s view while LPN #2 was working in a resident ' s room. During observations of medication administration on 1/31/13 from 5:33 AM to 6:48 AM, LPN #2 worked at the medication cart to prepare medications for administration to the residents. On four occasions (at 5:33 AM, 6:16 AM, 6:35 AM, and 6:48 AM) LPN #2 left the unattended med cart unlocked when she went into the residents ' rooms for medication administration. The medication cart was not within view of the nurse while she was in the resident ' s room. During an interview with the DON (Director of Nursing) on 2/1/13 at 11:40 AM, the DON indicated that her expectation would be that the medication cart would be locked (especially if not in view of the nurse) and the cart should be in the nurse's sight when they are working from it. The DON also stated, "I would expect that they lock the cart before walking away from it." 2. An observation of the 500 hall medication cart on 1/31/13 at 3:31PM, revealed the med cart was unlocked and unattended without a nurse on the hall. When Nurse #3 returned to the cart at 3:34 PM, she indicated that the medication cart should be locked at all times when not in use or when	F 431	in cart and medication rooms which included removing medications based on expiration dates, manufacturers expectations and procedure for returning expired medications to the pharmacy. This included the importance of locking medication carts. In-service completed 2/4/13 An audit has been completed the DON and administrative nurses of the facility medication cart and medication rooms to ensure that expired medications were not present .	

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	345291	A. BUILDING _____ B. WING _____	02/01/2013

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F 431	Continued From page 37 she is not at the cart. During an interview with the DON (Director of Nursing) on 2/1/13 at 11:40 AM, the DON indicated that her expectation would be that the medication cart would be locked (especially if not in view of the nurse) and the cart should be in the nurse's sight when they are working from it. The DON also stated, "I would expect that they lock the cart before walking away from it." 3. An observation of the 500 hall medication refrigerator on 1/31/13 at 3:38 PM revealed an open, undated vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis). The manufacturer ' s product information indicated opened vials should be discarded after 30 days. During an interview with Nurse #3 on 1/31/13 at 3:40 PM, the nurse indicated the opened vial should have been labeled with the date it was opened on the outside of the vial. Nurse #3 stated she believed this vial would need to be discarded after being opened for 30 days. During an interview with the DON (Director of Nursing) on 2/1/13 at 11:40 AM, the DON addressed the normal procedure for storing opened pharmaceuticals such as Tuberculin PPD injectable medication. The DON stated, "When they (nurses) open them they (the vials) should be dated." The DON also indicated anything that ' s not dated should be thrown away and a new vial opened. She noted that opened vials would usually be kept for 30 days or whatever the manufacturer or policy called for. 4) An observation of the 400 hall medication cart	F 431	The DON and Administrative nurses will complete weekly random audits while making rounds on the hall and during the scheduled medication administration observations to ensure that medication carts are locked, medication is secure and expired medications are not present. Audits will be completed daily X5 days then weekly times three weeks then monthly times 5 months and thereafter quarterly for one year. The DON will present a report of monitoring results to the quality assurance committee each month for 3 months then quarterly thereafter for a period of one year.	

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F 431	Continued From page 38 on 1/31/13 at 3:20 PM revealed Advair Diskus 250mcg/50mcg (a dry powder inhaler used for asthma or chronic obstructive lung disease) was removed from the overwrap pouch on 12/31/12 (1/31/13 was Day 31) and the inhaler had an opened expiration date of 3/31/13 noted on the label. Manufacturer product labeling indicates the Diskus device should be discarded 1 month after removal from foil pouch. During an interview with Nurse #4 on 1/31/13 at 3:20 PM, the nurse indicated the expiration date of 3/31/13 was being used as the last possible date of the opened inhaler's use. On 1/31/13 at 3:40 PM, the facility's consultant pharmacist provided written information to the DON (Director of Nursing) regarding the stability of Advair Diskus outside of the foil overwrap for greater than 30 days. Information provided included a six-point Summary of the findings. Pertinent summary points include: · According to the Prescribing Information provided by the manufacturer, Advair Diskus should be stored at controlled room temperature, 20o to 25o C (68o to 77o F) in a dry place away from direct heat or sunlight. In addition, Advair Diskus should be discarded 1 month after removal from the moisture-protective overwrap pouch or after every blister has been used, whichever comes first. GlaxoSmithKline cannot recommend the use of Advair Diskus when stored outside of these conditions. · Supplemental stability data indicate that the typical product performance of Advair Diskus (all strengths) is acceptable when used up to 3 months after storage at 25o C (77o F) and 75% relative humidity without the moisture-protective	F 431		

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F 431	Continued From page 39 overwrap, but not beyond the expiry date. In a telephone interview on 2/1/13 at 9:02 AM, a drug information specialist and PharmD (Doctor of Pharmacy) for the drug manufacturer (GlaxoSmithKline) stated the published information regarding stability of Advair Diskus outside of the foil overwrap for greater than 30 days is supplemental information only and not up to regulatory standards. Product and Prescribing Information from GlaxoSmithKline continues to indicate the Advair Diskus device should be discarded 1 month after removal from the moisture-protective overwrap pouch or after every blister has been used, whichever comes first. During an interview with the DON on 2/1/13 at 11:40 PM, the DON stated per protocol an Advair Diskus inhaler removed from the overwrap pouch should be good for 90 days. In a telephone interview on 2/1/13 at 1:48 PM with the facility's consultant pharmacist, the consultant pharmacist indicated the facility had been using a 3-month expiration date for Advair Diskus inhalers once removed from the overwrap based on the supplemental stability data. The consultant pharmacist indicated she was aware the manufacturer ' s Product and Prescribing information for Advair Diskus continues to specify the device should be discarded 1 month after removal from the moisture-protective overwrap pouch or after every blister has been used, whichever comes first.	F 431		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly	F 468	F468 The hand rail between the 300 and the 400 hall has been repaired. 2/1/13 Any handrail in the facility has the potential to be loose. Therefore, the maintenance director completed an audit of handrails throughout the facility to ensure they were tightened and any screw holes were filled with wood filler as needed. The maintenance director was in serviced by the administrator on 2/1/13 concerning preventive maintenance and the use of the handrail log and what to look for during daily rounds.	3/1/13

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F 468	Continued From page 40 secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, 1 of 5 hallways had hand rails that were not secured to the wall (hallway between 300 and 400 halls). Findings include: On 2/1/13 at 3:35 PM an Environmental Observation of the facility was conducted with Maintenance and the Director of Housekeeping. The observation revealed the hand rail in the hallway between the 300 and 400 halls was loose and coming detached form the wall. The screws that attached the hand rail to the wall were also noted to be loose and coming out. An interview with the facility's Maintenance Director was conducted on 2/1/13 at 3:35 PM concerning the loose hand rails on the hallway between 300 and 400 halls. The Maintenance Director indicated he had not been aware of any maintenance issues/problems with the 300-400 hallway hand rails.	F 468	Each week the maintenance director and or the administrator will check each hand rail to assure that they are still tight and have no splinters. A form has been developed to document these rounds and the results of anything in need of repair. The administrator will also check for the security of the rails each day as he makes rounds throughout the facility. A summary of monitoring efforts will be prepared by the maintenance director and presented to the quality assurance committee each month for 3 months and then quarterly thereafter for a period of 1 year.	

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

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	345291	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ MAR 0	8 2013 02/21/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II construction, one story, without a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K 018 The corridor door to the kitchen has had a new positive latching door knob installed on 2/21/13. The corridor door to the ice machine room had the space between the grills replaced with 2 pieces of 5/8"	
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: 42 CFR 483.70(a)	K 018	fire rated sheet rock. 3/9/13 The maintenance director will make weekly rounds to identify any life safety issues that have the potential to affect residents. Any issues identified to be a problem will be corrected immediately. A tool has been developed to monitor any problems. This form will be completed weekly by the maintenance director or the administrator. The results of this monitoring will be presented to the quality assurance committee each month for three months and then quarterly thereafter for one year.	

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

Administrator 3/7/13

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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K 018	Continued From page 1 By observation at approximately noon the following doors protecting corridor openings was non-compliant, specific findings include; A. The corridor door to the kitchen, across from room 144, did not have positive latching. B. The corridor door to the ice machine room had a grill in the door.	K 018	K 066 Ashtrays of noncombustible material and safe design have been purchased for the staff smoking area. A metal container with a self closing lid has been purchased and placed in the staff smoking area on 2/28/13. The housekeeping director will make weekly rounds to identify any life safety issues that have the potential to affect residents. Any issues identified to be a problem will be corrected immediately. A tool has been developed to monitor any problems. This form will be completed weekly by the housekeeping director or the administrator. The results of this monitoring will be presented to the quality assurance committee each month for three months and then quarterly thereafter for one year.	3/9/13
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a)	K 066		

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K 066	Continued From page 2 By observation at approximately noon the following smoking regulations were observed as noncompliant: specific findings include; A. Ashtrays of noncombustible material and safe design per paragraph 3 above were not provided in the employee smoking area. Employees were not directed to smoke in the designated area. The ground along the exit discharge path in the back of the building was used as the smoking area of choice instead of using ashtrays. B. A metal container with a self-closing cover into which ashtrays can be emptied in the employee smoking area per paragraph 4 above was not provided.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include; the deep fryer was located next to a cook top without the required splash guard or a distance of 18" from the cook top in the dietary kitchen. The fryer was moved over 18' from the cook top during the survey.	K 069	K 069 The deep fryer has been moved 18" from the cook top during the survey. The dietary manager will inspect the fryer for proper placement each week to ensure that it has not moved from its current location. She has developed a tool to monitor the placement of the fryer weekly. The results of this monitoring will be brought to the quality assurance committee each month for 3 months and then quarterly thereafter for a period of 1 year.	3/9/13