STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345302	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TRACE REHABILITATION & NURSING CENT	417 MOUNTAIN TRACE ROAD SYLVA, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a Care Area Assessment related to nutrition on the latest comprehensive Minimum Data Set for 1 of 21 sampled residents. (Resident #6). The findings included: Resident #6 was admitted to the facility 05/01/09 with diagnoses including poorly controlled diabetes mellitus, congestive heart failure, Alzheimer's disease, and history of stroke.

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 272	Continued From Page 1

A review of a dietary progress note dated 07/02/13 revealed Resident #6 had experienced a weight loss of 16 pounds (11.7%) over the past 180 days. Continued review of the dietary notes revealed the resident's weight had stabilized over the past 6 months due to diet modifications and dietary supplements.

An annual Minimum Data Set (MDS) dated 02/04/13 indicated Resident # 6 experienced memory loss and severely impaired cognition. The MDS specified the resident required extensive staff assistance for all activities of daily living including eating. Further review of the MDS revealed the resident experienced physical and verbal behavioral symptoms 4 to 7 days per week. The MDS specified the resident had experienced no significant weight loss or gain in the past 6 months. Resident #6 was assessed in the MDS as receiving a mechanically altered diet.

A review of the Care Area Assessment (CAA) associated with the nutritional review for this annual comprehensive MDS was conducted. This CAA specified the resident was on a pureed diet, resided on the memory unit, and was assisted by staff as needed. The CAA did not reflect the causes and contributing factors relating to nutrition for this resident. No complications or risk factors affecting Resident #6's nutritional status were described in the CAA.

An interview with the Food Service Director was conducted on 02/22/13 at 1:12 PM. She acknowledged the nutritional CAA for Resident #6's comprehensive assessment of 02/04/13 did not reflect the resident's nutritional status including causes, contributing, or risk factors.

An interview with the MDS Coordinator was conducted on 02/22/13 at 2:40 PM. She acknowledged the nutritional CAA for Resident #6's comprehensive assessment of 02/04/13 was not complete. The MDS Coordinator stated the CAA did not reflect the resident's causes, contributing, and risk factors related to the resident's nutritional status.

An interview with the Director of Nursing (DON) on 02/22/13 at 2:40 PM revealed she expected a CAA to reflect the resident's causes and contributing factors regarding nutrition. She stated by reading a CAA, the reader should know the resident. The DON acknowledged the nutritional CAA for Resident #6's 02/04/13 comprehensive assessment did not include these descriptions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TRACE REHABILITATION & NURSING CENTER	417 MOUNTAIN TRACE ROAD SYLVA, NC 28779

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews with residents and staff the facility failed to honor known food preferences and/or allergies for 3 of 5 sampled residents. (Residents #1, #28 and #160) The findings are: 1. Resident # 160 was admitted to the facility 02/15/13 with diagnoses which included subdural hematoma, anxiety and depression. The physician's diet order on admission was regular. The allergies listed in the medical record of Resident #160 included green beans. Although a Minimum Data Set assessment had not been completed on Resident #160 a note by the facility social worker dated 02/19/13 indicated, "Resident is able to make basic needs known to others." Review of the dietary tray card for Resident #160 noted green beans were included as both a dislike and a food allergy. Observations were made of the lunch meal service on 02/21/13 at 12:00 PM. Green beans		**Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set froth in the statement of deficiencies. The plan of correction is prepared ad or executed solely because it is required by the provisions of Federal and State law.** POC – Mountain Trace survey exit 2/22/13 **F242** – Resident #160 has tray diet card highlighted and flagged with allergy to green beans and is no longer receiving green beans. Resident #28 has tray diet card highlighted and flagged with dislike of potatoes and is no longer receiving potatoes on her trays. Resident #1 has tray card highlighted and flagged with dislike of green beans and is no longer receiving green beans. Current residents with dislikes and/or food allergies have the potential of being affected by this deficient practice although no others have been affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gene D Elliott — TITLE: Administrator — (X6) DATE: 3-18-13

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.

Original Signature Date: 3-13-13

DHSR WNY Plaza Mountain WRO Received MAR 19 2013 by: MMH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 242	Continued From page 1 were included as part of the preplanned lunch meal and were included on the tray of Resident #160. Resident #160 (as well as a family member) were interviewed at the time the tray was delivered and both indicated green beans were an allergy and, if eaten, caused anaphalatic shock. Resident #160 stated she did not plan on eating the green beans that had been included with the lunch meal. On 02/21/13 at 12:15 PM the Food Service Director (FSD) stated the dietary staff member plating food was responsible for reading each individual tray card to determine any allergies or food dislikes. The FSD stated the person loading the trays on the cart is supposed to review the tray card in conjunction with items served to ensure food was consistent with each residents dislikes and food allergies. The FSD could not explain why green beans had been served to Resident #160. 2. Resident #28 was admitted to the facility 05/14/12 with diagnoses which included mild cognitive impairment. The current Minimum Data Set assessment dated 1/30/13 assessed Resident #28 with moderately impaired cognition. A social worker assessment dated 02/21/13 noted, "Resident is able to make her basic needs known to others" and "Resident does best with closed ended questions." A review of the dietary tray card of Resident #28 revealed she was on a puree diet and had a dislike of cauliflower and potatoes. Observations were made of the lunch meal 02/18/13 at 12:15 PM. Resident #28 was	F 242	An audit of current resident tray cards was completed to ensure resident likes/dislikes are highlighted and flagged for easy identification. Education to the Dietary Department by the Dietary Manager regarding the procedure for honoring resident food preferences on meal trays will be completed by 3/15/13. Dietary Manager will conduct random audits of meal trays daily x 2 weeks, weekly x 2 weeks then monthly thereafter to verify food preferences and/or food allergies are being recognized and honored. Findings of these audits will be presented to the Quality Assurance committee by the Dietary Manager monthly x 3 months then quarterly thereafter to determine the need for additional education and/or monitoring. New dietary employees to receive the same education upon hire. **Compliance Date March 17, 2013**	

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F 242	Continued From page 2 observed eating lunch in the main dining room and being assisted with her meal by a staff member. Food served to Resident #28 included whipped potatoes and the potatoes were not eaten. At the end of the meal a staff member removed the plate from in front of Resident #28 and commented to the resident, 'you don't like potatoes, do you?'. Resident #28 replied, 'no' and that she ate too many potatoes growing up. The staff member feeding Resident #28 looked at the tray card and verified potatoes were listed as a dislike. Observations were made of the lunch meal on 02/21/13 at 12:05 PM in the main dining room. The lunch tray for Resident #28 included whipped potatoes. When asked, Resident #28 stated, I don't like potatoes. Potatoes were listed on the tray card as a dislike. At the time of the observation the Food Service Director (FSD) was made aware Resident #28 had been served potatoes which was listed as a dislike on the tray card. On 02/21/13 at 12:15 PM the Food Service Director (FSD) stated the dietary staff member plating food was responsible for reading each individual tray card to determine any allergies or food dislikes. The FSD stated the person loading the trays on the cart is supposed to review the tray card in conjunction with items served to ensure food was consistent with each residents dislikes and food allergies. The FSD could not explain why potatoes had been served to Resident #28. 3. Resident #1 was admitted to the facility 12/15/97 with diagnoses which included	F 242		

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F 242	Continued From page 3 Alzheimer's dementia. Review of the dietary tray card for Resident #1 revealed her diet order was puree and that she had a dislike of green beans. On 02/21/13 at 1:00 PM observations were made of food plated on the lunch tray for Resident #1. Puree green beans were included with the lunch meal. At the time of the observation the Food Service Director (FSD) verified the puree green food on the lunch tray of Resident #1 was green beans because it was the only pureed vegetable prepared for the lunch meal. On 02/21/13 at 12:15 PM the Food Service Director (FSD) stated the dietary staff member plating food was responsible for reading each individual tray card to determine any allergies or food dislikes. The FSD stated the person loading the trays on the cart is supposed to review the tray card in conjunction with items served to ensure food was consistent with each residents dislikes and food allergies. The FSD could not explain why green beans had been served to Resident #1.	F 242	Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set froth in the statement of deficiencies. The plan of correction is prepared ad or executed solely because it is required by the provisions of Federal and State law.	
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to follow house standing diet orders for 2 of 4 sampled	F 367		

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F 367	Continued From page 4 residents ordered a therapeutic diet. (Residents #45 and # 104) The findings are: 1. Resident #45 was admitted to the facility from the hospital on 12/8/12 with diagnoses which included dementia and diabetes. The hospital history and physical indicated Resident #45 had diabetes and to follow a diabetic diet. Physician admission orders included a diabetic diet. On 12/10/12 the diet order for Resident #45 was changed to a regular diet. House standing orders (revised 10/11/12) in the medical record of Resident #45 indicated: "Any resident that is admitted with a specific diet will be changed to diet on the house standing order that is equivalent. Diets are as follows: Regular, Limited Concentrated Sweets, No Added Salt, Mechanical Soft, Puree". Lab work done on Resident #45 on 12/11/12 included a Hemoglobin A1 level (a test which indicates the average level of blood sugar over the past 2 to 3 months) of 7.3 with a normal range of 4.5-5.7. Review of physician progress notes in the medical record of Resident #45 included a note on 12/13/12 which indicated: "This is an initial visit on this recently admitted patient with nursing staff concern for hyperglycemia in the context of treatment for recent pneumonia including Prednisone taper." The physician's assessment included, "I have assessed the course of this patient's diabetes, and the patient demonstrates acute changes requiring increased frequency in	F 367	**F367** –Resident #45 is receiving the diet ordered by the physician. Resident #104 is receiving the diet ordered by the physician. Current residents have the potential of being affected by this deficient practice although none were found to be affected.	

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F 367	Continued From page 5 monitoring as well as adjustments in the medical regimen. Some of this influence may be from her Prednisone taper. Will discontinue Glimerpiride (an oral diabetic medication), and increase Lantus (insulin) to 12 units in the morning and evening. Will monitor subsequent blood sugars closely, and consider short-acting insulin pre-meals, if patient nutrition intake is consistent. Plan recheck in about 2 weeks." On 02/21/13 at 5:00 PM the facility consultant dietitian (RD) stated her understanding of diets at the facility was that only liberal diets were provided which included texture modifications of regular, mechanical soft and puree. The RD stated she was aware of the house standing orders dated 10/11/12 but was told by the Food Service Director (FSD) to only use texture modification. The RD stated she changed any therapeutic diet orders to indicate texture modifications only. The RD stated this was the case involving Resident #45 which was how the diet order was changed on 12/10/12. The RD stated she did not speak to the resident's physician (who is also the medical director) before changing the diet order nor was she aware of his expectation related to diet orders. On 2/21/12 at 01:45 PM the physician of Resident #45 stated he expected facility staff to follow the house standing diet orders. The physician of Resident #45 stated he was not aware the registered dietitian was changing therapeutic diet orders to an order which included only texture modifications of regular, mechanical soft or puree. The physician of Resident #45 stated if a diabetic diet was ordered he expected the resident to receive foods that were low in	F 367	The physician standing orders have been changed per the medical director to correlate with the facility policy for diets made available. Education to the Registered Dietician, Dietary Manager, facility physicians and nurse practitioners was completed by the Director of Nursing on the facility policy for physician approved and available diets. Residents will be placed on a regular diet unless contraindicated per physician or Registered Dietician assessment. Individual diets may be further modified by physician or Registered Dietician as needed per resident preference. Therapeutic diets outside the liberalized diet plan will be referred to Registered Dietician for review/clarification. An audit was completed of current residents to ensure that the physician ordered diet is being provided by the facility. The Dietary manager will make random audits of at least 5 trays daily x 2 weeks, weekly x 2 weeks then monthly thereafter to ensure physician ordered diets are provided to the residents.	

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F 367	Continued From page 6 concentrated sweets. The physician of Resident #45 stated he had not been notified of such changes. On 02/22/13 at 01:25 PM the FSD stated she was aware of the house standing orders related to diet orders but that she and the consultant RD wanted to have liberalized diets so any therapeutic restrictions were changed by the RD to a texture modification of regular, soft or puree. The FSD stated she had not spoken to the medical director about their practice to ensure it met his expectations. The FSD stated this was the reason the admission diet order of Resident #45 had been changed from diabetic to regular on 12/10/12. The facility preplanned menus were reviewed with the FSD and included a plan for a limited concentrated sweets diet. Modifications on a limited concentrated sweet diet included serving a sugar substitute, unsweetened beverage and a smaller portion of concentrated sweet desserts. On 02/22/13 at 04:00 PM the Director of Nursing and administrator stated they would expect diet orders to be consistent with the house standing orders and physician orders unless otherwise approved by speaking to the physician.. 2. Resident #104 was initially admitted to the facility on 11/21/12 and readmitted 01/23/12 with diagnoses which included coronary artery disease, end stage renal disease and diabetes mellitus.	F 367	Findings of these audits will be presented to the Quality Assurance committee by the Dietary Manager monthly x 3 months then quarterly thereafter to determine the need for additional education and/or monitoring. New dietary employees to receive the same education upon hire. **Compliance Date March 17, 2013**	

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F 367	Continued From page 7 Review of resident #104's most recent Minimum Data Set (MDS) dated 12/03/12 revealed she was assessed as cognitively intact. Record review of hospital discharge physician orders dated 11/18/12 and 01/18/12 revealed Resident #104 was discharged from the hospital with orders for a diabetic diet. Review of the facility House Standing Orders (HSO), revised 10/11/12, located in Resident #104's medical record read: "Any resident that is admitted with a specific diet will be changed to diet on the HSO that is equivalent. Diets are as follows: Regular, Limited Concentrated Sweets, No Added Salt, Mechanical Soft, Puree." Review of lab work completed on 12/12/12 for Resident #104 included a Hemoglobin A1c level of 6.3 with a normal reference range of 4.2-5.8 and a high phosphorus level of 5.8 with a normal reference range of 2.5-5.0. A review of communication received from the dialysis center regarding blood chemistry values was conducted. This review revealed Resident #104 had high phosphorus levels and recommendations were made to limit high phosphorus foods such as cheese, ice cream, pudding, yogurt, milk, dried beans, peas, whole wheat bread, brown rice, bran, granola or whole grain cereals. Review of Resident #104's tray card listed only dislikes which was fish and rice. Medical record review revealed the diabetic diet	F 367		

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F 367	Continued From page 8 was changed on 12/12/12 by the Registered Dietician (RD) to regular diet, regular consistency, and full range of liquids. This request was written as a physician ' s order and signed only by the RD and not the physician. On 02/21/13 at 5:00 PM an interview was conducted with the facility consultant Registered Dietician (RD). The RD stated she was aware of the HSO orders but was told by the Food Service Director (FSD) to only use texture modifications such as regular, mechanical soft, and puree on facility diets. The RD revealed she changed therapeutic diet orders to indicate texture modifications only. The RD indicated Resident #104 was to have low potassium foods listed on her tray card and was not aware the only food items listed on the tray card were dislikes of fish and rice. The RD revealed she had not spoken to the physician (who was also the Medical Director) before changing diet orders. She stated she was not aware of the physician s expectation related to diet orders. On 02/21/13 at 1:45 PM an interview was conducted with the facility Medical Director (physician of Resident #104). He stated he expected the facility staff to follow the HSO for diets. The physician voiced he was not aware the RD was changing therapeutic diet orders to an order which included only texture modifications of regular, mechanical soft or puree. He said the main issue for residents ordered a diabetic diet was to receive foods low in concentrated sweets. The physician of Resident #104 stated he was not notified by the dietician on diet changes and had not been aware diets were being changed.	F 367		

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F 367	Continued From page 9 On 02/22/13 at 12:38 PM an interview was conducted with the Food Service Director (FSD). She stated she was aware of HSO related to diet orders. She said liberalized diets provided therapeutic restrictions changed by the RD to a texture modification of regular, mechanical soft or puree. The FSD revealed she had not spoken to the Medical Director about his expectations related to texture modifications of diets. The FSD revealed that a list of low potassium foods were not placed on resident tray cards only dislikes and food allergies. She acknowledged Resident #104 had only fish and rice listed as a dislike on her tray card. The FSD stated if Resident #104 wanted a dessert such as cake there would be no low sugar or sugar free cake. She would receive a smaller portion of the cake constituting a limited concentrated sweet food. On 02/22/13 at 4:00 PM an interview was conducted with the Administrator and Director of Nursing. They stated they would expect diet orders to be consistent with the house standing orders, signed physician orders, or otherwise approved by speaking to the physician.	F 367	**Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set froth in the statement of deficiencies. The plan of correction is prepared ad or executed solely because it is required by the provisions of Federal and State law.**	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F441 -Resident #6 did not suffer any harm due to the nurse incorrectly cleaning the glucometer after use. Nurse #1 was immediately educated on proper cleaning of the glucometer. Nurse #1 no longer is employed at the facility. Residents receiving finger stick blood sugar tests have the potential of being affected by this deficient practice although none were found to be affected.	

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F 441	Continued From page 10 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to disinfect a blood glucose monitor (glucometer) after use per manufacturer's instructions for 1 of 2 residents during observations of blood sugar monitoring. (Resident #6). The findings included:	F 441	Education provided to licensed nursing staff by the Director of Nursing on proper cleaning procedures of the glucometer machines. The Director of Nursing will make random observations of cleaning procedures of glucometer machines by nurses daily x 2 weeks then weekly x 2 weeks. These observations will be documented on a Quality Assurance Tool. Findings of these audits will be presented to the Quality Assurance Committee by the Director of Nursing monthly x 3 then quarterly thereafter to determine the need for additional education and/or monitoring. New licensed staff to receive the same education upon hire. Compliance date March 17, 2013	

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F 441	Continued From page 11 A facility glucometer user manual dated 03/11 specified disinfecting could be completed by using a commercially available Environmental Protection Agency (EPA) registered germicidal wipe. To use a wipe, follow product label instructions to disinfect the meter. A review of the instructions provided by the manufacturer of the EPA registered germicidal disposable wipe utilized by the facility was conducted. The directions specified to accomplish disinfection of a hard surface, unfold a wipe and thoroughly wet the surface. Treated surface must remain visibly wet for a full 2 minutes. Use additional wipe(s) if needed to assure continuous 2 minute wet contact time. Let air dry. An observation was conducted on 02/20/13 at 11:30 AM of Nurse #1 obtaining a finger stick blood sugar (FSBS) reading. Nurse #1 was observed entering Resident #6's room and utilized a glucometer to obtain a FSBS reading on the resident. Upon completion, Nurse #1 returned to the medication cart. She wiped the glucometer with a germicidal wipe and immediately placed the glucometer back into the storage section of the medication cart. Nurse #1 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes. An interview with Nurse #1 at this time revealed her normal practice when disinfecting glucometers was to wipe the glucometer off with a germicidal wipe and to immediately store it in the medication cart. She stated she was unaware of the need to keep the glucometer wet with the germicidal solution for a full 2 minutes.	F 441		

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F 441	Continued From page 12 The glucometer was disinfected utilizing manufactures instructions before reusing. An interview with the Director of Nursing on 02/20/13 at 1:01 PM revealed nursing staff had been trained to ensure the glucometer was wet with germicidal solution for a full 2 minutes. She stated her expectation was for staff to follow the procedure the way they were trained by the facility.	F 441	Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set froth in the statement of deficiencies. The plan of correction is prepared ad or executed solely because it is required by the provisions of Federal and State law.	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean a fan and ice machine in the facility kitchen. The findings are: 1. During the initial tour of the facility kitchen on 02/18/13 at 10:20 AM a fan was observed in use and blowing air toward the facility dish machine area. The fan was mounted on the wall, at ceiling height. The fan was turned off by the Food Service Director (FSD) and the front and back grills and fan blades were noted to have a build-up of dust which covered a significant portion of the surface area. The FSD stated the	F 456	F456 -Fan was immediately removed from the kitchen and thoroughly cleaned. The fan has been removed from the kitchen area. A new wall mounted is being installed and a cleaning schedule has been added. The ice machine was thoroughly cleaned and a cleaning schedule developed for each.	

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F 456	Continued From page 13 fan was supposed to be cleaned by dietary aides but that it had been inadvertently left off the kitchen cleaning schedule. 2. On 02/20/13 at 10:30 AM observations were made of the interior of the ice machine located in the facility kitchen. The left hand interior wall had an irregular shaped brown looking matter which measured approximately 12" X 3". White piping in the right rear of the interior of the ice machine had an approximate 8" X 4" dark brown matter. The areas were wiped with a paper towel and the brown matter was easily removed from both the wall and white piping. The Food Service Director (FSD) was present at the time of the observation and stated dietary aides were responsible for wiping down the interior of the ice machine. The FSD checked the kitchen cleaning schedule and reported the need for cleaning the ice machine had been inadvertently left off the cleaning schedule.	F 456	Education provided by the Administrator to Dietary staff and Maintenance staff regarding proper cleaning of equipment in the kitchen. The Dietary Manager will conduct random observations of the fan in the kitchen checking for cleanliness daily x 2 weeks then weekly ongoing. These audits will be documented on a Quality Assurance Audit Tool. The Maintenance Director will conduct random audits of the ice machine in the kitchen to ensure cleanliness daily x 2 weeks then weekly. These audits will be documented on a Quality Assurance audit tool. Findings of the audits will be presented by the Dietary Manager and the Maintenance Director to the Quality Assurance committee monthly x 3 then quarterly thereafter to determine the need for additional education and/or monitoring. New dietary and maintenance employees to receive the same education upon hire.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to obtain a urinalysis for 1 of 10 sampled residents that were reviewed to determine if physician orders were completed as ordered. (Resident #57) The findings are:		Compliance date March 17, 2013	

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F 502	Continued From page 14 Resident #57 was admitted to the facility 11/13/12 with diagnoses which included pneumonitis, dysphagia, muscle weakness, abnormal gait, acute respiratory failure and salmonella gastroenteritis. Review of the medical record revealed a physician progress note dated 01/24/13 which indicated, "This is an acute visit to assess patient for complaint of dysuria (painful urination)" and "Dysuria; at risk for urinary tract infection. Check urinalysis to assess status and treat if warranted." The physician wrote an order on 01/24/13 to check urinalysis and culture and sensitivity. Review of lab results in the medical record of Resident #57 revealed a urinalysis and culture and sensitivity was not done as ordered on 01/24/13. On 02/20/13 at 6:00 PM the Director of Nursing (DON) confirmed the urinalysis had not been done as ordered by the physician. The DON reviewed the facility policy for completing physician ordered labs which included: 1) The nurse that writes the order for lab work writes a requisition slip (top copy for the lab, bottom copy to be given to the DON) 2) The DON gives the bottom copy to the unit supervisor in the next morning meeting for follow-up 3) The nurse writes a nurses note, contacts the family and pharmacy about the order 4) The night shift nurse does a chart check every night to ensure all orders have been processed and writes "24 check" next to each new order to verify it had been checked. 5) Two separate facilities are used for labwork; one during the week and one on the weekend and the nurse would notify the appropriate lab of the need for work via the	F 502	**Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set froth in the statement of deficiencies. The plan of correction is prepared ad or executed solely because it is required by the provisions of Federal and State law.** F502 – The follow up urinalysis for resident #57 was performed on 2/21/13 and the results were Negative. Residents with physician orders for a urinalysis test have the potential to be affected by this deficient practice although none were found to be affected. Education to licensed staff by the Director of Nursing on policy and procedure for lab services. Lab orders will be monitored by the Unit Manager ensuring lab tests ordered has a result to match order. The Unit Manager will audit lab orders/results daily M-F. These audits will be documented on a Quality Assurance Audit Tool daily x 2 weeks, weekly x 2 weeks then randomly thereafter. Agency licensed staff and new employees to receive the same education upon hire.	

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F 502	Continued From page 15 requisition slip. The DON stated the lab requisition had not been written which would have initiated the whole process for the lab work being completed. The DON also stated that third shift nursing staff failed to do the chart check as "24 check" was not written next to the physician order. After reviewing the resident's medical record and facility records the DON stated the only acknowledgment she could find of the 01/24/13 order for a urinalysis was on the 24 hour shift report utilized by nursing staff. The DON identified Nurse #2 as the nurse that took the order for the urinalysis for Resident #57 on 01/24/13. On 02/21/13 at 9:15 AM Nurse #2 confirmed she wrote the order for the urinalysis for Resident #57 on 01/24/13. Nurse #2 stated she could not recall what happened after the order was written and didn't remember obtaining a urine sample from Resident #57. Nurse #2 stated her normal procedure was to fill out the lab requisition slip and keep it on her personal clipboard to remind her to get the specimen. Nurse #2 stated the sample along with the lab requisition slip would be placed in the 300 hall refrigerator for the lab to pick up. Nurse #2 stated if she did not get the specimen she would have passed on the lab requisition slip to the oncoming shift for them to do. Nurse #2 stated she could not explain what happened and why the urinalysis was not done for Resident #57. On 02/21/13 at 2:00 PM the physician of Resident #57 stated he expected lab work to be completed as ordered. On 02/22/13 at 11:00 AM the DON stated since	F 502	Findings of these audits will be presented to the Quality Assurance Committee by the Director of Nursing monthly x 3 then quarterly thereafter to determine the need for additional education and/or monitoring. New licensed staff to receive the same education upon hire. Compliance date March 17, 2013	

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F 502	Continued From page 16 the omission of the 01/24/13 urinalysis was brought to her attention, a urinalysis was done on Resident #57 and it was negative.	F 502		