STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY NURSING AND REHABILITATION CENTER	714 WESTOVER DRIVE SANFORD, NC 27330

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 4/18/13. Event ID# 7MAV11.	F 000		

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

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to develop a plan of care for impaired vision for 1 of 3 sampled residents (Resident #37) reviewed for visual function. The findings included: Resident #37 was admitted into the facility on 8/9/12. Diagnoses included Cataract, Dry Eye, and Pseudophakia (replacement of the natural eye lens with an artificial lens). The quarterly minimum data set (MDS) completed on 2/4/13 indicated Resident #37 memory was severely	F 279	**F000** **Disclaimer** The statements made on this plan of correction are not an admission of nor constitute an agreement with the alleged deficiency. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that the alleged deficiency has been or will be corrected by the date or dates indicated. **F279** **For the residents involved, corrective action has been accomplished by:** Resident #37 Care Plan has been updated by MDS Coordinator to include visual function. Resident #37 care plan now includes details of decreased visual acuity due to cataracts and pseudophakia along with the use of a magnifier for reading newspaper and other reading materials. A follow up appointment has been made with Dr. Miles Whitaker, OD for 5/10/13 at 10:00am. The facility will provide transportation to this appointment. **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** The CAA's were reviewed for all residents to identify any resident that triggered for decrease visual acuity.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Andrews — TITLE: Administrator — (X6) DATE: 5/10/13

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 279	Continued From page 1 impaired. Vision was indicated as impaired, sees large print, but not regular print in newspaper and/or books. The care area assessment (CAA) summary dated 11/12/12 indicated as a problem focus "decreased visual acuity". The most recent care plan dated 12/7/13 did not indicate visual function as an identified problem. A review of the on-sight senior care eye form indicated that Resident #37 was last evaluated by the eye doctor on 5/25/11. The eye doctor recommended a follow up visit due to "cataracts, dry eye and pseudophakia". In an interview on 4/18/13 at 8:45 am, Resident #37 stated that he liked to read the newspaper but had trouble seeing the words. He indicated that he could not see the print of the monthly calendar of events that was posted on the wall in his room. He concluded the facility had not provided any adaptive equipment such as a magnifier glass, wherein, he could read the print better. On 4/18/13 at 8:47 am, the monthly calendar of events was observed posted 4 feet on the wall away from Resident #37's position in the bed. In an interview on 4/18/13 at 8:53 am, Nurse #1 when asked regarding Resident #37 reliability stated he was aware of his surrounding and able to communicate his needs to the staff. In an interview on 4/18/13 at 8:55 am, the MDS when asked why there was not a care plan for visual function stated she had missed that Resident #37 had diagnoses that included cataract, dry eye, and pseudophakia. She added	F 279	27 residents were identified and care plans were reviewed to ensure visual issues were care planned. 5 residents had vision care plan updated. Care Plans were reviewed by an interdisciplinary team including DON, MDS, Nurses, Nursing Assistants and Rehab staff. Appropriate MD orders obtained for follow up as needed. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur:** In-service was provided for nursing staff (RN's and LPN's) MDS Coordinator and Social Worker on communication and care planning requirements. Topics included: Care planning individual needs or problems in resident centered format on admission, with review and update on any significant change and quarterly with the interdisciplinary team. Ensuring that the care plan currently reflect any problems/needs with approaches effective to provide the best possible resident outcome. The facility is contracted with On-Site Eye Care. They visit the facility approximately twice a year and audits are completed to insure that all resident's eyes are examined at least annually. Any follow up appointments or consultations that are recommended by On-Site would be scheduled according to our facility policy. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees,	

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F 279	Continued From page 2 that she was not aware that a follow up appointment was recommended by the eye doctor. In an interview on 4/18/13 at 9:40 am, the director of nursing indicated she expected if vision triggered on the CAA as an identified problem a care plan was initiated for visual function.	F 279	and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. On Site Senior Eye Care recommendations will be discussed at the daily Clinical Meeting. The Clinical Meeting includes DON, MDS Nurse, Health Information Manager, Rehab Director, Dietary Mgr. and Administrator.	5/10/13
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: Based on record review, family interview, and staff interviews, the facility failed to notify the designated legal representative of scheduled care	F 280	**The facility has implemented a quality assurance monitor:** Using the QA Survey Tool, the DON or her designee will check three residents' records and ensure that a Care Plan is developed and updated as needed for vision issues. Any recommendations for follow up are completed or documentation available describing outcome. This will be done weekly for four weeks, then monthly for two months. Identified issues will be reported immediately to DON or ADM. for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting, which is attended by the DON, MDS Coordinator, Health Information's Manager, Dietary Manager, Social Worker, and Administrator and other members as needed.	

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F 280	Continued From page 3 plan meetings to ensure the representative's active participation in the plan of care for 2 of 2 sampled residents (Resident #37, #46). The findings included: 1. Resident #37 was admitted into the facility on 8/9/12. Diagnoses included Rehabilitation. The quarterly minimum data set (MDS) completed on 2/4/13 indicated Resident #37 memory was severely impaired. A review of the last mailed care plan meeting notification provided by the former social services coordinator was dated 7/25/12 as being mailed to the designated legal representative (DLR). In an interview on 4/16/13 at 2:50 pm, the designated legal representative with Resident #37 present indicated she had not attended a care plan meeting in a while (no specific time frame indicated), nor had she received a notification letter by the facility of any upcoming care plan meetings for Resident #37. The DLR stated that she was the person to be notified regarding the care of Resident #37. Resident #37 added that he had not attended a care plan meeting to discuss any plans regarding his care. In an interview on 4/17/13 at 10:29 am, the director of nursing stated that both the MDS nurse and the social worker oversaw the care plan meetings. She indicated that the social worker was ultimately responsible for ensuring that the DLR was notified via a mailed letter of the date/time that the care plan meeting would be held. In an interview on 4/17/13 at 10:32 am, the MDS	F 280	**F280** **For the residents involved, corrective action has been accomplished by:** Resident #37 and #46 legal representatives have been contacted by mail/phone and offered the opportunity to participate in additional care plan meeting on 5/2/13 for #37 and attended by his legal representative and hospice representative. For resident #46 a care plan was held and attended by family on 4/29/13. **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents have the potential to be affected by this alleged practice. A Care Plan audit was completed on all current residents on May 7. 2013 and care plans are scheduled. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur** Briggs Form#830 "Care Plan Postcard" was ordered on 5/8/2013. The form is a two part form, one side has the postcard that will be sent to the patient and/or legal representatives inviting them to the care plan conference, giving the date and time, and asking that the RSVP. The second part of the form is a tear off tab that will list the patients name, date invite was mailed, and boxes to check if the attended or not. This second part will be kept in a file/notebook.	

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F 280	Continued From page 4 nurse stated that the procedure for notifying the DLR regarding care plan meetings included a mailed letter to the DLR with the scheduled date/time that the care plan meeting would be held. In an interview on 4/17/13 at 10:36 am, the social services coordinator stated he was new to his position at the facility and was in the process of coordinating a better system for ensuring that the DLR received notification of the care plan meetings. He indicated that he not mailed any letters to Resident # 37's DLR which notified of any scheduled care plan meetings. In an interview on 4/17/13 at 11:49 am, the former social services coordinator stated she had no additional mailed care plan meetings on file beyond 7/25/12 that were mailed to Resident #37's DLR. In an interview on 4/17/13 1:44 pm, the director of nursing indicated she expected the DLR to be notified by the social services department a couple of weeks prior to the scheduled care plan conference, to ensure that the DLR participated in the meeting. In an interview on 4/18/13 at 8:53 am, Nurse #1 when asked regarding Resident #3 reliability stated he was aware of his surrounding and able to communicate his needs to the staff. 2. Resident # 46 was admitted to the facility on 8/4/11 with diagnoses of cerebral vascular accident and anoxic brain damage. A review of the quarterly Minimum Data Set (MDS) dated 4/8/13 indicated that resident #46	F 280	**The facility has implemented a quality assurance monitor:** The MDS Coordinator will review three residents having a quarterly/annual MDS within the prior month to ensure a care plan invitation was offered and the Care Plan meeting occurred with the interdisciplinary team. This will be done weekly for four weeks, then monthly for two months. Identified issues will be reported immediately to the DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the DON, [redacted] Nurse, MDS Coordinator, Rehab, Health Information Manager, Dietary Manager, ADM, Social Worker, and other members as needed.	5/8/13

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F 280	Continued From page 5 had severe cognitive impairment and required extensive assistance will all activities of daily living. In an interview with resident #46's responsible party on 4/16/13 at 11:40 AM, she indicated she was the contact person for resident #46 and at one time she was getting an invitation to care plan meetings. She stated she could not recall when she last received an invitation or was notified of a care plan meeting. In an interview on 4/17/13 at 10:15 AM, the director of nursing (DON) stated that the MDS nurse and the social services coordinator were responsible for sending out the invitations to the responsible parties for care plan meetings. She stated that the care plan meetings are held every Wednesday and Thursday. In an interview with the MDS nurse and the social services coordinator on 4/17/13 at 10:45 AM, the MDS nurse stated that the new social services coordinator was still in training and it will eventually be his responsibly to notify responsible parties and mail out the care plan invitations. The MDS stated she was doing the care plan invitations until the social services coordinator was trained. The MDS nurse stated she had not sent out any care plan invitations in the last two weeks since the previous social services coordinator left.She stated she used a calendar to know when a resident' s quarterly care plan meeting was due and that she always tried to accommodate the responsible party's schedule. The MDS nurse stated the business office person actually physically mailed out the care plan invitations once they were completed by the	F 280		

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F 280	Continued From page 6 social services coordinator. The social services coordinator on 4/17/13 at 10:45 AM, he stated he started his position 2 weeks ago and the MDS was training him. In an interview on 4/17/13 at 11:45 AM, the previous social services coordinator confirmed she worked at the facility for 2 years up until 2 weeks ago. She provided a copy of the care plan initiation sent to resident #46's responsible party dated 8/1/12 for 2:30 PM. She also provided evidence of a care plan invitation for resident #46's responsible party dated 5/2/12 for 1:30 PM. There was no other provided evidence of care plan meetings or invitations for 2012 for resident #46. A review of the social services notes from May 2012 to present only revealed documentation of the required MDS assessment quarterly and a room change note/ dated 2/19/13. There were no notes documented regarding any planning and scheduling on care plan meetings. In an interview with the medical records supervisor on 4/17/13 at 1:20 PM, she confirmed no thinned social services notes or records were flied elsewhere. In an interview with the DON on 4/17/13 1:45 PM, she stated her expectation was for all responsible parties of the residents be invited to quarterly care plan meetings.	F 280		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and	F 313	**F313** **For the residents involved, corrective action has been accomplished by:** Resident #37 has a follow up appointment with Dr. Miles Whitaker on Friday, May 10, 2013 at 10:00 am. Resident #37 now has a magnifier glass available for his use in order to see newspaper or other reading materials.	

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F 313	Continued From page 7 hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to follow up on an eye appointment for visual impairment for 1 of 3 sampled residents (Resident #37) reviewed for vision function. The findings included: Resident #37 was admitted into the facility on 8/9/12. Diagnoses included Cataract, Dry Eye, and Pseudophakia (replacement of the natural eye lens with an artificial lens). The quarterly minimum data set (MDS) completed on 2/4/13 indicated Resident #37 memory was severely impaired. Vision was indicated as impaired, sees large print, but not regular print in newspaper and/or books. The care area assessment summary dated 11/12/12 indicated as a problem focus "decreased visual acuity". The most recent care plan dated 12/7/13 did not indicate visual function as an identified problem. A review of the on-sight senior care eye form indicated that Resident #37 was last evaluated by the eye doctor on 5/25/11. The eye doctor recommended a follow up visit due to "cataracts, dry eye and pseudophakia". In an interview on 4/17/13 at 2:52 pm, the MDS	F 313	**Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents' medical records were reviewed for consultant reports in the last month for any recommendations for follow up appointments for treatment of vision. No residents had follow up appointments recommended. On-Site Eye Care will return for the semi-annual checks in August. Any resident needing eye exams will be scheduled for that visit. All residents were audited to determine if any residents would benefit from adaptive equipment for improved vision. 14 residents were provided magnifiers. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur:** All nurses (RN and LPN) were in serviced on 5/7/13 by the DON on resident appointments, consult sheet, recommendations/orders and follow up appointments. Those not in attendance will be required to review the in-service education print out and have an opportunity to ask questions prior to working. Starting 5/7/13, a new duplicate form from Briggs will be used to schedule all resident appointments. This includes follow up appointments, referrals and consultations. When the nurse receives a follow up appointment, physicians' progress note with follow up recommendation, consultation request or physicians order, the appointment request will be written on the transportation requisition form.	

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F 313	Continued From page 8 nurse stated that the social services coordinator usually coordinated the eye appointments to ensure the residents were seen during the onsite visits by the eye doctor. In an interview on 4/17/13 at 3:25 pm, the social services coordinator indicated that Resident #37 had not been seen by the eye doctor since 5/25/11. He added that he was new to his position at the facility and was in the process of coordinating a better system for the facility, to ensure that residents were evaluated by the eye doctor. In an interview on 4/18/13 at 8:45 am, Resident #37 stated that he liked to read the newspaper but had trouble seeing the words. He concluded the facility had not provided any adaptive equipment such as a magnifier glass, wherein, he could read the print better. In an interview on 4/18/13 at 8:53 am, Nurse #1 when asked regarding Resident #37 reliability stated he was aware of his surrounding and able to communicate his needs to the staff. In an interview on 4/18/13 at 9:40 am, the director of nursing indicated she expected the MDS nurse during the chart review to have reviewed Resident #37 medical records in its entirety to ensure that Resident #37 was seen by the eye doctor per his recommendation.	F 313	The white top copy will be forwarded to the transportation aide and the yellow copy will be placed in the medication book with the resident's MAR. The transportation aide will schedule the appointment, place the appointment on the master schedule, schedule the transportation and notify the family of the appointment date and time. The white copy will be filled out completely and then be returned to the medication book with the resident's MAR, so that the nurse is aware of all upcoming appts. These changes are to give the transportation aide more control over the efficiency of the transportation process, as well as to improved communications with nursing and responsible parties. A QA tool has been created to measure compliance with this process and the auditing program will be reviewed at the weekly Quality Assurance Meeting. **The facility has implemented a quality assurance monitor:** Using the QA Survey Tool, the SDC/QA Nurse will review three residents having had an appointment with a consulting MD or service in the past week to ensure all recommendations and appts. were completed. This will be done weekly for four weeks then monthly for two months. Identified issues will be reported immediately to the DON or ADM for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly QA Meeting. The weekly QA Meeting is attended by the DOJN, Wound Nurse, MDS Coordinator, Therapy, HIM, Dietary Mgr., Social Worker and ADM and other members as needed.	5/10/13
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		

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F 318	Continued From page 9 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to continue a hand splint to the left hand and failed to verify noncompliance to wear the hand splint prior to being discontinued for 1 of 2 sampled residents (Resident #37) reviewed for contracture's. The findings included: Resident #37 was admitted into the facility on 8/9/12. Diagnoses included Left Hemiplegia, Cerebrovascular Accident (Stroke), and Rehabilitation. The quarterly minimum data set (MDS) completed on 2/4/13 indicated Resident #37 memory was severely impaired. Limitation in range of motion was indicated as "impaired" to both upper extremities (shoulder, elbow, wrist, hand). Physical and occupational therapy services were not indicated as received. Range of motion, splint/brace devices were not indicated as received. The most recent care plan dated 12/7/13 identified contracture's as a problem. There was no indicated splint device listed as an intervention or Resident #37 refusal to wear a splint device to the left hand. A review of the occupational therapist (OT) discharge assessment note signed on 7/26/12 for splinting indicated Resident #37 therapy goal was met. Discharge from occupational therapy was indicated on 5/15/12 with orders that included a	F 318	**F318** **For the residents involved, corrective action has been accomplished by:** Resident #37 was reassessed (screened) by therapy on 5/8/13. A new Left hand splint has been ordered. When it arrives, a formal evaluation by OT will be performed and followed by staff training and follow up. **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents with splints and contractures have the potential to be affected by this alleged practice. An audit was done on 5/8/13 of all residents with splints and contractures to ensure device is present and in use per care plan and according to the MD order. The audit revealed that 1 resident of 44 did not have splints as care plan and M/D order. Splint was immediately ordered. When received, OT will begin treatment, followed by staff training and follow up. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur:** On May 8, 2013 an in-service was provided by the Rehab Director for nursing staff (RN and LPN) and NA's. Those not in attendance will be required to review the in-service documentation and ask questions before they can return to work Content of the in-service was splints; applications, skin integrity checks,	

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	345216	A. BUILDING _____ B. WING _____	C 04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY NURSING AND REHABILITATION CENTER	714 WESTOVER DRIVE SANFORD, NC 27330

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F 318	Continued From page 10 splint to the left upper extremity (hand splint) for the purpose to reduce further progressing/development of contractures. A review of a telephone order dated 8/28/12 indicated the OT discontinued the splint wear schedule without a rationale. A review of the nurses' notes from May 2012 through April 2013 revealed that Resident #37 did not refuse for the hand splint to be applied. On 4/16/13 at 10:10 am, Resident #37 left fingers, left hand and left arm was observed in a contracted - fixed state. The left arm was positioned inward toward the body. There was no splint or supportive device observed to the left fingers, left hand or left arm. On 4/16/13 at 12:16 pm, Resident #37 when asked could he move his left fingers, left hand, and left arm was unable to perform the task. He was observed to use his right hand to position and lift the left upper extremity. All five fingers on the left hand were positioned inward toward the palm of the hand. There was no splint or supportive device observed to the left fingers, left hand or left arm. On 4/17/13 at 2:08 pm, there was no splint or supportive device observed to Resident #37 left fingers, left hand or left arm. In an interview on 4/17/13 at 2:20 pm, NA (nursing assistant) #1 who worked 7 am - 3 pm stated she had not applied a hand splint on Resident #37 left (hand, fingers, arm) as part of daily care, but she had provided range of motion	F 318	observation for any discomfort with the device and reporting any issues including refusal to wear splint to the Nurse and rehab director for appropriate interventions along with the required documentation.. The residents care plan should reflect any splints needed for each resident. Splint order will also be placed on the MAR. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the QA Committee. If a resident has a contracture or positioning need, nursing will document need and notify therapy and the MD for therapy referral order. Therapy will screen and evaluate the resident for the appropriate equipment or splint to meet the resident's need. An MD order is obtained to include the splint, indication for use, application, and schedule for use. In-service is provided by therapy to staff on correct application to don and doff the device. The device order is placed on the MAR. The Care Plan is updated to reflect the device and fired to the NA through smart-charting in AHT for documentation. M-F the DON or MDS nurse will review any new MD orders for splints and positioning devices to ensure they are transcribed to the MAR. Any issue will be reported immediately to the DON and or ADM with appropriate follow up.	

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F 318	Continued From page 11 exercises to the left upper extremity on the weekend. In an interview on 4/17/13 at 2:40 pm, the MDS nurse stated approaches to prevent Resident #37 left upper extremities (fingers, hand, arm) from worsening included implementing the plan of care to move all joints in a slow manner. She added that upon admission residents were assessed, and if any identified problem was observed in between a quarterly assessment, a referral to the therapy department would be initiated. In an interview on 4/17/13 at 3:15 pm, the physical therapist when questioned regarding Resident #37 left (hand, fingers, arm) indicated her professional assessment as of 4/17/13 upon being made aware by the state agency stated "The left upper extremity revealed adduction (close to body) contracture's, wherein, the arm when assessed was difficult to move as a result of positioning and lack of movement to the left upper extremities due to stoke". The PT concluded that based upon the occupational discharge assessment dated 5/15/12 a hand splint was to continue to the left hand. In an interview on 4/17/13 at 4:17 pm, NA #2 indicated that she was the primary NA for Resident #37 on 3 pm - 11 pm shift. She added that splint application and range of motion exercises to the left upper extremity (hand, fingers, arm) was not a part of the care that she provided due to not being listed on the care plan. In an interview on 4/18/13 at 9:20 am, the OT stated she discontinued the hand splint because the nursing staff (no name provided) informed her	F 318	This will be reviewed at the Daily Clinical Meeting (M-F). The Clinical Meeting includes DON, Rehab Dir., MDS, HIM, Dietary, ADM and other clinical staff as needed. The MDS nurse will update the care plan and send information to the NA for documentation. **The facility has implemented a quality assurance monitor:** Using the QA Survey Tool, the DON, Rehab Director or designee will check three residents that have splints to ensure the device is present, in good condition, applied properly, resident is comfortable in the device and it is removed as ordered. Documentation is completed on the MAR indicating the device was used per MD order. This audit will be done weekly for four weeks then monthly for two months. Identified issues will be reported immediately to the DON or ADM for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting attended by the DON, MDS Coordinator, Therapy, HIM, Diet. Mgr. SW, ADM and other members as needed.	5/10/13

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F 318	Continued From page 12 that Resident #37 did not use the hand splint, and would not allow the staff to put the splint on. The OT concluded that the hand splint was a rental and needed to be returned due to non-use. In an interview on 4/18/13 at 9:37 am, the director of nursing stated she expected if Resident #37 refused for the hand splint to be applied that the clinical record should reflect such, prior to the splint being discontinued.	F 318		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to 1) label and date open food items 2) to store dented cans in designated area from ready eat foods and 3) change gloves after possible contamination. The findings included: 1. Observation was made on 04/15/13 at 6:30 PM of the following items in the dry food storage area: opened fudge brownie cake mix with no date; opened corn bread mix with no date and two dented cans of lemon pudding stored on the shelf with ready to eat foods.	F 371	**F371** **For the residents involved, corrective action has been accomplished by:** No residents were involved in this alleged observation. All identified opened unlabeled food items were disposed of. All identified dented cans were removed from ready eat foods and placed in the designated area. Open and unlabeled food items in dry food storage were disposed of. Unlabeled and undated food items found in the reach in refrigerator were disposed of. Staff identified not changing gloves between going from the reach in refrigerator back to the steam table was immediately in serviced on proper glove usage. Staff were also reminded that they are to wash hands and change gloves after being soiled and serving utensils should be used on the steam table to serve food items.	

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F 371	Continued From page 13 A Second observation was made on 04/17/13 at 11:41 AM in the dry storage area and the following was observed: opened fudge brownie cake mix with no date; opened corn bread mix with no date and two dented cans of lemon pudding stored on the shelf with ready to eat foods. 2. Observation was made on 04/15/13 at 6:45 PM of the following food items in the reach in refrigerator with no date: ham, roll of ground beef, opened bag of shredded cheese, sliced bologna, turkey breast and an open bag of pre-boiled eggs. A Second observation was made on 04/17/13 at 11:25 AM of the reach-in refrigerator of 2 packs of sliced bologna with no date. 3. Observation was made on 04/17/13 at 11:24 AM of the cook in the kitchen with gloved hands opening the door of the reach in refrigerator and going back to steam table and using same gloved hands to pickup baked fish without a serving utensil. 4. Observation was made on 04/17/13 at 12:00 PM of the cook wiping sweat with towel and gloved hands and going directly back to the steam table without changing gloves and washing hands. Interview with the Cook on 04/18/13 at 12:10 PM revealed that he should have washed his hands and changed gloves after touching the refrigerator door and wiping his sweat. The Cook further stated that he usually uses a spatula to	F 371	**Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** Dietary Manager removed dented cans from the ready to eat foods area and destroyed, disposed of all unopened, undated dry storage products, any item in the walk-in refrigerator that was unlabeled and/or undated were disposed of. Staff were in-service that they are to wash their hands and change gloves after being soiled. Also that serving utensils should be used on the steam table to serve food items. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur:** In-service education was provided to dietary staff by the Registered Dietician Consultant. Reviewed policy and procedures for labeling and dating food items, procedure to follow for dented cans, proper food handling, proper hand washing and glove use, serving food. Any staff member not present will be required to review the in-service education materials and ask questions before returning to work.	

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F 371	Continued From page 14 serve the baked fish. Interview with the Certified Dietary Manager (CDM) on 04/18/13 at 2:20 PM revealed that it is her expectation that the open items are dated with the expiration date when they are opened. The CDM further stated that open items in the dry storage should be put in a zip lock bag or plastic container with a lid. The container should be dated and labeled and all dented cans should be stored in the designated area for dented cans. The CDM stated that food service staff should wash hands and change gloves after they have been soiled and serving utensils should be used on the steam table to serve food items.	F 371	**The facility has implemented a quality assurance monitor:** Using the QA Survey Tool, the Dietary Manager will audit labeling and dating of food items, food storage, proper food handling and personal hygiene once weekly for four weeks then monthly for two months. Identified issues will be reported immediately to Registered Dietician and ADM. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA meeting is attended by the DON. MDS Coordinator, Therapy, HIM, Dietary Manager, Administrator, Social Services and other members as necessary.	5/9/13

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	345216	A. BUILDING 01 - MAIN BUILDING 01 JUN 0 3 2013 B. WING _____	05/21/2013

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, and is not equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a) NOTE: The facility is underway with a replacement facility.	K 000	**F000** **Disclaimer** The statements made on this plan of correction are not an admission of nor constitute an agreement with the alleged deficiency. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that the alleged deficiency has been or will be corrected by the date or dates indicated.	
K 032 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 5/21/2013 the following Life Safety item was observed as noncompliant, specific findings include: The exit egress door near room 117 was dragging on the threshold when tested during the survey. CFR#: 42 CFR 483.70 (a)	K 032	**K032** **Corrective action taken by to correct the deficient practice has been accomplished by:** The egress door near room 117 was repaired so that it no longer drags on the threshold. **Identifying other life safety issues having the potential to affect residents by the same deficient practice and corrective action taken:** Audit was done on all exit egress doors to ensure that doors were not dragging on threshold.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Andrews — TITLE: Administrator — (X6) DATE: 5/31/13

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.

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

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	345216	A. BUILDING 02 - BUILDING 02 B. WING _____	05/21/2013

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, and is not equipped with an automatic sprinkler system. Building 2 is not occupied. CFR#: 42 CFR 483.70 (a) NOTE: The facility is underway with a replacement facility.	K 000	**Measures put into place or systemic changes made to ensure that the deficient practice does not occur:** Maintenance Director will audit exit doors weekly to assure compliance. Any exit egress doors found not opening and closing correctly will be immediately repaired. **The facility has implemented a quality assurance monitor to ensure the deficient practice will not reoccur:** A QA tool has been developed to be completed weekly and reported to QOL Committee monthly. **Date of Compliance: 5/22/13**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Andrews
TITLE: Administrator
(X6) DATE: 5/31/13

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.