STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 HIGHWAY 70 SWANNANOA, NC 28778

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the physician and the	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All deficiencies have been or will be completed by the dates indicated. F157 **How the corrective action will be accomplished for the resident(s) affected.** The Physician and RP were notified of their fall during the time of the survey for Resident # 3 and 6. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** On July 1, 2013, the prior Administrator completed all staff education regarding notification of Medical Doctor (MD) and Responsible Party (RP) after a fall. An audit of all falls from 6/28/13 to 7/25/13 was completed on 7/25/13 to ensure notification of MD and RP.	7/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan L Gibbs — TITLE: Administrator — (X6) DATE: 8/1/13

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 7-25-13mh

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F 157	Continued From page 1 responsible party following a fall for 2 of 3 sampled residents reviewed with falls. (Residents #3 and #6). The findings included: The facility's policy for Incident/Accident Reports in the Nursing Documentation manual with an effective date of 01/06/12 included the following procedures: *"The attending physician will immediately be notified of the occurrence." *"A licensed nurse will immediately notify the responsible party of the occurrence." *"Documentation and verification of the follow up to the care and treatment of the resident as well as notification of the physician and responsible party will be completed in the Nurses Notes." 1. Resident #3 was admitted to the facility on 03/13/13 with diagnoses including Alzheimer's type dementia with behavioral disturbances, major depressive disorder, generalized anxiety disorder, coronary artery disease, hypothyroidism, and hyperlipidemia. The admission Minimum Data Set (MDS) dated 03/20/13 coded her with severely impaired cognitive skills, and requiring supervision with bed mobility, transfers, and walking. Review of an incident report, written by Nurse #6, revealed on 05/09/13 at 6:45 PM Resident #3 was observed on the floor in her room on the side of the bed, kneeling on the floor mat with the alarm sounding. The incident report's section relating to notifications to the physician and to the responsible party were left blank.	F 157	**Measures in place to ensure practices will not occur.** The Administrator, Interim Director of Nursing (IDON), Unit Manager (UM) or designee will audit any falls on the next business day regarding notification of physician and responsible party for a period of 2 weeks, weekly x two weeks, then monthly x 2, then quarterly x 3. The Staff Development Coordinator (SDC)/ DON/UM will ensure annual and new nurse hire education on RP and MD notification. **How the facility plans to monitor and ensure correction is achieved and sustained.** The IDON or Unit Manager will present results of audits to Quality Assessment Committee monthly for 3 months, then quarterly x 3 to show compliance with education and allow for review and revision if needed.	

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F 157	Continued From page 2 The corresponding progress note dated 05/09/13 at 11:53 PM revealed the resident fell at 6:45 PM but gave no mention of any notification to the doctor or the responsible party. The only nursing note on 05/10/13 was timed at 3:41 PM and again gave no mention of any notifications. Interview with the Regional Nurse Consultant and Administrator on 06/28/13 at 4:10 PM revealed notifications should be documented on the incident report, in the nursing notes or on the care plans. The care plan did not address notifications. Interview with Nurse #6 on 06/28/13 at 6:54 PM revealed when a resident fell he was responsible for filling out an incident report. He stated there was a spot on the form to complete regarding notification of the physician and responsible party. He stated that he called the physician and responsible party right away if the resident was injured. If there was no injury, he may wait until he made his progress note and if it was too late in the evening by the time he wrote his note or he ran out of time he passed it on to the next shift (usually 11-7) to call or leave a message for the next day's first shift to make the notifications. He further stated if he was left the assignment from another shift to make the notification, he would document that notification was made in the nursing notes. He also stated he was not sure of the policy for notification but he was trying to do a better job notifying the physician and responsible party after a fall. 2. Resident #6 was admitted to the facility on 03/13/13 with diagnoses including Alzheimer's	F 157		

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F 157	Continued From page 3 type dementia with behavioral disturbances, major depressive disorder, generalized anxiety disorder, coronary artery disease, hypothyroidism, and hyperlipidemia. The admission Minimum Data Set (MDS) dated 03/20/13 coded her with severely impaired cognitive skills, and requiring supervision with bed mobility, transfers, and walking. She was coded as being steady with balance at all times. Review of an incident report, written by Nurse #6, revealed that on 05/09/13 at 8:45 PM Resident #6 was observed on the floor in her room sitting on the floor mat with no alarms sounding. The alarm had been on but the cord was so long it didn't disconnect and sound. The incident report's section relating to notifications to the physician and to the responsible party were left blank. The corresponding progress note dated 5/09/13 at 11:48 PM revealed that Resident #6 was on the floor at 8:45 PM. There was no documentation regarding notification of the physician or the responsible party. The 2 nursing notes on 05/10/13 at 3:40 PM and again at 11:46 PM referred to the fall, however, there was no indication that notification was made to the physician or responsible party at these times either. Interview with the Regional Nurse Consultant and Administrator on 06/28/13 at 4:10 PM revealed notifications should be documented on the incident report, in the nursing notes or on the care plans. The care plan did not address notifications.	F 157		

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F 157	Continued From page 4 Interview with Nurse #6 on 06/28/13 at 6:54 PM revealed when a resident fell he was responsible for filling out an incident report. He stated there was a spot on the form to complete regarding notification of the physician and responsible party. He stated that he called right away if the resident was injured. If there was no injury, he may wait until he made his nursing note. Then, if it was too late or he ran out of time he passed it on to the next shift (usually 11-7) to call or leave a message for the next day's first shift to make the notifications. He further stated if he was left the assignment from another shift to make the notification, he would document that notification was made in the nursing notes. He also stated he was not sure of the policy for notification but he was trying to do a better job notifying the physician and responsible party after a fall.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	F225 **How the corrective action will be accomplished for the resident(s) affected.** Resident #7 incident was reported to the State agency by the prior Administrator.	7/26/13

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F 225	Continued From page 5 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an allegation of an injury of unknown origin within 24 hours and submit by the 5th working day the investigation for 1 of 3 residents sampled for abuse investigations. (Resident #7) The findings included: Resident #7 was admitted to the facility on 04/21/13 with diagnoses including congestive heart failure, diabetes, neuropathy, chronic renal insufficiency, right hip fracture, chronic obstructive pulmonary disease, and gastroesophageal reflux disease.	F 225	**How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** All current Staff were in-serviced on Abuse and Neglect Policy and reporting requirements by the prior administrator. The prior Administrator and Interim Director of nursing (IDON) were educated on reporting to other officials in accordance with State and Federal Regulations by the Nurse Consultant on June 28th. The new Interim DON (IDON) and prior Administrator were educated on July 22, 2013 by the Nurse Consultant to report injuries of unknown origin within 24 hours and submit the results of the investigation by the 5th working day. The Administrator will be responsible for completing the 24 hour Report and 5 day investigation report. **Measures in place to ensure practices will not occur.** Incident and Accident reports are audited on the next business day by IDON and reviewed by Administrator, to ensure that any injuries not explained are investigated and reported as needed. Staff who continue to	

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F 225	Continued From page 6 Review of the medical record revealed a progress note dated 05/01/13 at 2:19 PM written by the Administrator which noted a trickle of blood from the right nare. The resident stated she had nose bleeds all the time. A progress note dated 05/02/13 at 3:08 PM written by the Administrator stated a family conference was held this date. This note stated the family was aware of the resident's nosebleeds and added that the resident would often blow her nose with a nosebleed making the bleed worse. A progress note on 05/05/13 at 2:25 PM stated Resident #7 had been yelling out throughout the morning. A family came in and was concerned about the resident's mental status. Resident #7 subsequently was sent to the hospital per family request. The resident returned about 7:50 PM per the progress note dated 05/06/13 at 6:17 AM. This progress note stated the CT scan of the head showed age appropriate changes. The note continued stating the family was "not pleased, that she is still with 'delirium'." The CT scan's impression noted findings were consistent with small vessel/microvascular disease and age appropriate involutional changes. Progress notes dated 05/07/13 at 3:45 PM revealed Resident #7 was noted with frequent nose bleeds of small amount frank blood. At approximately 1:00 PM the resident was noted to have moderate amount of frank red blood with grape sized clot that she had 'spit up'. Resident stated she could feel the blood coming up from her throat and filling the back of her mouth. Emergency Medical Services was notified immediately and the resident was transported to the emergency room for evaluation and treatment.	F 225	turn in Incident and Accident Reports that are incomplete or fail to timely report allegations of abuse will be re-educated and continued non-compliance will result in disciplinary action. **How the facility plans to monitor and ensure correction is achieved and sustained.** The IDON will report the results of the audit to the QA Committee for three months, then quarterly x 3 for compliance and revision as needed.	

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F 225	Continued From page 7 Progress notes dated 05/07/13 at 10:12 PM noted that at 6:35 PM, the resident was returned to the facility. Family stated 'they found a crack in her nose'. The progress note included the CT results noting a fracture in the nasal bone. No new orders were noted. Review of the CT scan completed at the hospital dated 05/07/13 at 5:07 PM included the impression "Possible subtle acute or old traumatic irregularity of the anterior nasal spine with soft tissue swelling." On 05/09/13 the physician progress note indicated he was seeing Resident #7 to review her medications and due to a bruise on her forehead and right eye. The physician stated she was on plavix and aspirin and he saw no signs or indications of abuse or neglect. The note did not mention the CT scan of 05/07/13 or fractured nose. Review of the abuse investigations revealed no 24 hour or 5 day report of an investigation regarding the fractured nose found on 05/07/13. Interview with the Administrator on 06/28/13 at 9:35 AM revealed the facility's investigation of an injury of unknown origin included attempting to find the root cause of the injury. She stated the nurse who noted the injury should have filled out an incident report and started an investigation. The Administrator stated they had investigated the red eye and determined it was from rubbing her eyes and the oxygen tubing rolling on her face. When asked about any investigation of the fractured nose, the Administrator stated the	F 225		

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F 225	Continued From page 8 resident had a fall at home and nose bleeds at home. The Administrator acknowledged the CT scan on 05/05/13 did not note a fractured nose and the one completed on 05/07/13 did show a fractured nose. The Administrator stated there was no investigation of the fractured nose because the family stated the resident had nose bleeds at home. She further stated the fractured nose caused the nose bleeds but could not say how or who made this conclusion nor did she provide any evidence to support this conclusion. When asked if the newly diagnosed fractured nose should have been investigated as an injury of unknown origin, the Administrator stated yes unless the family was in agreement that it could have happened at home. The Administrator further stated that in the context of the family interview confirming Resident #7 had nose bleeds at home she thought the reason was validated and there was no need to investigate it as a new injury and therefore did not report it to the state agency as being investigated. On 06/28/13 at 12:38 PM Resident #7's physician was interviewed via telephone. The physician stated he recalled hearing about the fractured nose but could not recall if a nurse told him or if the CT scan was in his folder to review when he came to the facility. He stated since he saw no bruising he did not think it was acute. He stated he did not have the CT scan to review in front of him during this conversation but stated the scan would say acute fracture if it was acute. He stated he concluded the fracture was not recent but was not sure about the reporting requirements. He further stated he was not concerned about the fractured nose and there was nothing to be done about it.	F 225		

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F 225	Continued From page 9 On 06/28/13 at 1:18 PM a family member was contacted by phone who acknowledged being at the hospital on 05/07/13 and being informed by the hospital physician that Resident #7 had a fractured nose. This family member stated he heard nothing more from the facility about the fractured nose. On 06/28/13 at 1:42 PM a telephone interview was conducted with Nurse #11, who was working when Resident #7 returned from the emergency room on 05/07/13 with the report of a fractured nose. Nurse #11 stated the family told her about the findings and she saw the CT report which she put in the physician's book as he was in the facility at this time. Nurse #11 stated the physician stated he did not see it as acute and there were no new orders. She then stated that for injury of unknown origin, she would report it to the physician, inform the unit manager and in his absence pass it on in shift report. In this case she recalled passing it on in shift report. Nurse #11 further explained that the unit manager brought all new injuries to the morning meetings where administration would discuss it. Nurse #11 stated she did not fill out an incident report regarding this fracture and nor would she fill one out for an injury of unknown origin. On 06/28/13 at 2:12 PM another family member, also present at the hospital on 05/07/13 when the fractured nose was discovered, was interviewed by telephone. The family stated that the facility's reason for sending Resident #7 to the hospital was for coughing up grape sized blood clots. This family member stated the fractured nose did not appear on the CT scan taken two days earlier	F 225		

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F 225	Continued From page 10 and was a new development. On 06/28/13 at 6:08 PM interview with Nurse #2 stated when he discovered Resident #7 had a fractured nose he was surprised. Without any reason for the fracture, such as a fall, Nurse #2 stated if he was the nurse responsible at the time, he would have filled out an incident report and given it to the Administrator to investigate.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to investigate a fractured nose as an injury of unknown origin for 1 of 3 residents sampled for abuse investigations. (Resident #7). The findings included: The facility's policy "Determination Guidelines" with an effective date of 08/03/11 included: "2. Injuries of unknown origin should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the State Survey Agency if there is reasonable cause to believe or suspect that an injury has been inflected upon a patient by a nurse aide or other Center staff." The facility's policy "Investigation and Reporting Protocols" with an effective date of 01/06/12	F 226	F226 **How the corrective action will be accomplished for the resident(s) affected.** Resident #7 incident was investigated and reported to the State agency by the prior Administrator. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.**	7/26/13

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F 226	Continued From page 11 included "3. The Administrator and/or Director of Nursing will immediately begin a thorough internal investigation of the alleged occurrence and will report with 24 hours of knowledge of the allegation." Resident #7 was admitted to the facility on 04/21/13 with diagnoses including congestive heart failure, diabetes, neuropathy, chronic renal insufficiency, right hip fracture, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. Review of the medical record revealed a progress note dated 05/01/13 at 2:19 PM written by the Administrator which noted a trickle of blood from the right nare. The resident stated she had nose bleeds all the time. A progress note dated 05/02/13 at 3:08 PM written by the Administrator stated a family conference was held this date. This note stated the family was aware of the resident's nosebleeds and added that the resident would often blow her nose with a nosebleed making the bleed worse. A progress note on 05/05/13 at 2:25 PM stated Resident #7 had been yelling out throughout the morning. A family came in and was concerned about the resident's mental status. Resident #7 subsequently was sent to the hospital per family request. The resident returned about 7:50 PM per the progress note dated 05/06/13 at 6:17 AM. This progress note stated the CT scan of the head showed age appropriate changes. The note continued stating the family was "not pleased, that she is still with 'delirium'." The CT scan's impression noted findings were consistent with small vessel/microvascular disease and age appropriate involutional changes.	F 226	All current Staff were in-serviced by the Administrator on Abuse and Neglect Policy and reporting The Administrator and Interim Director of nursing were educated on investigating and reporting to other officials in accordance with State and Federal Regulations by the Nurse Consultant on June 28, 2013. The new Interim DON was educated on July 22, 2013 and given a copy of the policy and regulatory requirements by the Nurse Consultant on investigating and reporting injuries of unknown origin within 24 hours and submit the results of the investigation by the 5th working days. The Administrator will be responsible for completing the 24 hour Report and the 5 day Investigation Report. **Measures in place to ensure practices will not occur.** Incident and Accident reports are audited on the next business by IDON and reviewed by Administrator, to ensure that any injuries not explained are investigated for cause and reported to State authorities as indicated. Staff who continue to	

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F 226	Continued From page 12 Progress notes dated 05/07/13 at 3:45 PM revealed Resident #7 was noted with frequent nose bleeds of small amount frank blood. At approximately 1:00 PM the resident was noted to have moderate amount of frank red blood with grape sized clot that she had 'spit up'. Resident stated she could feel the blood coming up from her throat and filling the back of her mouth. Emergency Medical Services was notified immediately and the resident was transported to the emergency room for evaluation and treatment. Progress notes dated 05/07/13 at 10:12 PM noted that at 6:35 PM, the resident was returned to the facility. Family stated 'they found a crack in her nose'. The progress note included the CT results noting a fracture in the nasal bone. No new orders were noted. Review of the CT scan completed at the hospital dated 05/07/13 at 5:07 PM included the impression "Possible subtle acute or old traumatic irregularity of the anterior nasal spine with soft tissue swelling." On 05/09/13 the physician progress note indicated he was seeing Resident #7 to review her medications and due to a bruise on her forehead and right eye. The physician stated she was on plavix and aspirin and he saw no signs or indications of abuse or neglect. The note did not mention the CT scan of 05/07/13 or fractured nose. Review of the abuse investigations revealed no investigation regarding the fractured nose found	F 226	turn in Incident and Accident Reports that are incomplete or fail to timely report allegations will be educated and if continued will result in disciplinary action **How the facility plans to monitor and ensure correction is achieved and sustained**. The IDON will report results of the audits to the QA committee for three months, then quarter x 3 for continued compliance and revision as indicated	

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F 226	Continued From page 13 on 05/07/13. Interview with the Administrator on 06/28/13 at 9:35 AM revealed the facility's investigation of an injury of unknown origin included attempting to find the root cause of the injury. She stated the nurse who noted the injury should have filled out an incident report and started an investigation. The Administrator stated they had investigated the red eye and determined it was from rubbing her eyes and the oxygen tubing rolling on her face. When asked about any investigation of the fractured nose, the Administrator stated the resident had a fall at home and nose bleeds at home. The Administrator acknowledged the CT scan on 05/05/13 did not note a fractured nose and the one completed on 05/07/13 did show a fractured nose. The Administrator stated there was no investigation of the fractured nose because the family stated the resident had nose bleeds at home. She further stated the fractured nose caused the nose bleeds but could not say how or who made this conclusion nor did she provide any evidence to support this conclusion. When asked if the newly diagnosed fractured nose should have been investigated as an injury of unknown origin, the Administrator stated yes unless the family was in agreement that it could have happened at home. The Administrator further stated that in the context of the family interview confirming Resident #7 had nose bleeds at home she thought the reason was validated and there was no need to investigate it as a new injury. On 06/28/13 at 12:38 PM Resident #7's physician was interviewed via telephone. The physician stated he recalled hearing about the fractured	F 226		

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F 226	Continued From page 14 nose but could not recall if a nurse told him or if the CT scan was in his folder to review when he came to the facility. He stated since he saw no bruising he did not think it was acute. He stated he did not have the CT scan to review in front of him during this conversation but stated the scan would say acute fracture if it was acute. He stated he concluded the fracture was not recent but was not sure about the reporting requirements. He further stated he was not concerned about the fractured nose and there was nothing to be done about it. On 06/28/13 at 1:18 PM a family member was contacted by phone who acknowledged being at the hospital on 05/07/13 and being informed by the hospital physician that Resident #7 had a fractured nose. This family member stated he heard nothing more from the facility about the fractured nose. On 06/28/13 at 1:42 PM a telephone interview was conducted with Nurse #11, who was working when Resident #7 returned from the emergency room on 05/07/13 with the report of a fractured nose. Nurse #11 stated the family told her about the findings and she saw the CT report which she put in the physician's book as he was in the facility at this time. Nurse #11 stated the physician stated he did not see it as acute and there were no new orders. She then stated that for injury of unknown origin, she would report it to the physician, inform the unit manager and in his absence pass it on in shift report. In this case she recalled passing it on in shift report. Nurse #11 further explained that the unit manager brought all new injuries to the morning meetings where administration would discuss it. Nurse #11 stated	F 226		

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F 226	Continued From page 15 she did not fill out an incident report regarding this fracture and nor would she fill one out for an injury of unknown origin. On 06/28/13 at 2:12 PM another family member, also present at the hospital on 05/07/13 when the fractured nose was discovered, was interviewed by telephone. The family stated that the facility's reason for sending Resident #7 to the hospital was for coughing up grape sized blood clots. This family member stated the fractured nose did not appear on the CT scan taken two days earlier and was a new development. On 06/28/13 at 6:08 PM interview with Nurse #2 stated when he discovered Resident #7 had a fractured nose he was surprised. Without any reason for the fracture, such as a fall, Nurse #2 stated if he was the nurse responsible at the time, he would have filled out an incident report and given it to the Administrator to investigate.	F 226		
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 record reviews and staff interviews the facility staff failed to promote dignity when they spoke to a resident in a demeaning way for 1 of 13 sampled residents. (Resident #14). The findings included:	F 241	F241 **How the corrective action will be accomplished for the resident(s) affected.** The Statement by the Nursing Instructor was investigated and unsubstantiated. The accused Certified Nurse Assistant was suspended and counseled on dignity and respect.	7/26/13

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F 241	Continued From page 16 Resident #14 was admitted to the facility on 05/07/10 with diagnoses which included heart disease, high blood pressure, kidney disease, diabetes, Alzheimer's disease and anxiety disorder. A review of the most recent annual Minimum Data Set (MDS) dated 04/02/13 indicated Resident #14 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #14 required extensive assistance from staff for activities of daily living but only required supervision by one staff for eating. Section E of the MDS for behaviors indicated Resident #14 exhibited no behaviors towards self or others. A review of a handwritten note dated 06/18/13 by a Nurse Aide (NA) Instructor indicated at 9:30 AM she observed NA #3 walk past the dining room and NA #3 stated to Resident #14 "your disgusting, that's disgusting; and you have the nerve to complain about other people touching your food." During an interview on 06/25/13 at 2:48 PM with the NA Instructor, she verified she was the Program Instructor for Nurse Aides in training and had students in the facility each week on Tuesday and Thursday. The NA Instructor explained she was standing in the hallway near the dining room on 06/18/13 at 9:30 AM and saw NA #3 point with her finger at Resident #14 and said you are disgusting, that's disgusting to take food off other resident's trays and you have the nerve to complain about other people touching your food.	F 241	**How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The Administrator in-serviced All Staff on July 1, 2013 regarding Employee and Resident Handbook information on dignity and respect and the consequences of maintain resident dignity and respect. **Measures in place to ensure practices will not occur.** Social Services (SS)/Discharge Planner(DP)/ will interview ten (10) residents that are able to respond to questions if they are treated with respect and dignity: daily Mon-Fri for 2 weeks; weekly for 2 weeks; then monthly for 2 months investigating if they have been treated with dignity and respect. The Administrator will also monitor the monthly Resident Council minutes for violations of dignity and respect. Any deviations will be immediately addressed by the Administrator. **How the facility plans to monitor and ensure correction is achieved and sustained.** The Social Worker will report the	

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F 241	Continued From page 17 She verified she wrote the handwritten note dated 06/18/13 and reported her observations and gave the note to the Director of Nursing (DON) immediately. She stated when she returned with NA students on Thursday 06/20/13 she was told the DON was no longer there and was not given any information about whether the incident had been investigated. During an interview on 06/27/13 at 2:53 PM with NA #3 she verified Resident #14 routinely tried to reach for other resident's food and tried to eat off trays that had already been eaten or from trays that hadn't been passed to residents. She explained Resident #14 usually ate breakfast and lunch in the dining room and then she went down the halls and grabbed food off the meal carts. She confirmed Resident #14 was grabbing food off the meal cart on the East hall on 06/18/13 around 8:30 AM and she told Resident #14 you know better, you're not supposed to touch other people's trays. NA #3 stated around 9:30 AM Resident #14 transported herself in her wheelchair toward the dining room. She stated she did not remember anyone talking to her about the NA Instructor's concerns. During an interview on 06/28/13 at 9:45 AM the Administrator verified she did not interview the NA instructor or investigate what the NA Instructor heard NA #3 say to Resident #14 on 06/18/13 at 9:30 AM. She also verified she did not interview NA#3 about what the NA Instructor reported because she thought the DON had done that. The Administrator stated an interview with the NA Instructor should have been done but it was not done. She further stated she had no evidence of what the DON did with the	F 241	results of Resident interviews to the QA committee for 3 months, then quarterly x 3 for review of compliance and revision to plan as needed.	

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F 241	Continued From page 18 information that was given to her on the handwritten note by the NA instructor and she would expect for there to be more detailed notes of the investigation than there was.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to include interventions on a care plan to monitor a resident from putting her hands in other resident's food and failed to include interventions on the care plan to monitor a resident who was restricted from a nursing hall for 2 of 17 sampled residents.	F 279	F279 **How the corrective action will be accomplished for the resident(s) affected.** The Care Plan for Resident #14 was updated to include behaviors of putting her hands in other resident's food. The care plan was updated for resident #8 to reflect the resident was no longer on restrictions. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Resident Care Plans with behaviors were reviewed to ensure all interventions are current. The IDON/Unit Managers (UM) will be educated on updating the Care Plan by the Quality Improvement Nurse by 7/26/2013.	7/26/13

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F 279	Continued From page 19 (Residents #14 and #8). The findings included: 1. Resident #14 was admitted to the facility on 05/07/10 with diagnoses which included esophageal reflux, thyroid disorder, anxiety disorder and Alzheimer's disease. The most recent annual Minimum Data Set (MDS) dated 06/28/13 indicated Resident #14 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #14 required set up and one staff person assistance with eating. A review of care plans with a revised date of 04/10/13 indicated a problem statement that Resident #14 was unable to complete activity of daily living tasks independently related to generalized weakness and cognition. The approaches indicated to provide meal set up and encourage Resident to eat foods and drink fluids. The Care plans did not have any interventions listed to prevent Resident #14 from putting her hands in other resident's food. During an interview on 06/27/13 at 2:53 PM with NA #3 she explained Resident #14 tried to reach for other resident's food and tried to eat off the trays that have already been eaten or resident's trays that haven't been passed. She explained it used to be an occasional thing for Resident #14 to reach for other resident's food but in the last 8 months it has gotten worse. She further explained Resident #14 ate breakfast and lunch in the dining room but when she finished she	F 279	**Measures in place to ensure practices will not occur.** The IDON/Unit Managers (UM) will audit three (3) charts weekly during Nursing Management Meeting to ensure all interventions have been placed in the Care Plan. Any variances will be monitored for patterns and trending. **How the facility plans to monitor and ensure correction is achieved and sustained.** The IDON will report the results of the audits to the QA Committee monthly for 3 months, then quarterly x 3 for continued compliance/revision to the plan.	

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F 279	Continued From page 20 came back to the hall and tried to take food off the meal cart. During an interview on 06/28/13 at 7:41 AM the Unit Manager explained care plans were a multidisciplinary process. He stated he remembered that a recommendation was made to put Resident #14's behavior for reaching for other resident's food on the care plan and it should be on there. The Unit Manager reviewed Resident #14's current care plans and confirmed there were no interventions listed on the care plans to monitor Resident #14 to prevent her form putting her hands in other resident's food. During an interview on 06/28/13 at 3:56 PM the Administrator stated it was her expectation for the interventions to prevent Resident #14 from reaching for other resident's food to be listed on the care plan. 2. Resident #8 was admitted to the facility on 07/01/11 with diagnosis that included seizures, depression, blood disorders, difficulty walking and a stroke. A review of the most recent (quarterly) Minimum Data Set (MDS) dated 06/28/13 indicated Resident #8 was cognitively intact and was independent with transfers and locomotion by wheelchair in the facility. The MDS further indicated Resident #8 had upper extremity impairment on one side. A review of a facility document titled "Service Concern Report" dated 05/20/13 indicated Resident #8 had been moved to the east hall of the facility and was restricted from the west hall of	F 279		

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F 279	Continued From page 21 the facility because of previous interactions with other residents. A review of care plans revealed there were no care plans with interventions listed to restrict Resident #8 from the west hall of the building. A review of a care plans dated 07/13/11 indicated there were no specific interventions listed to monitor Resident #8 from going to the west hall of the facility. During an interview on 06/25/13 at 1:45 PM with Nurse Aide (NA) #1 he stated he routinely provided care for Resident #8. He further stated he had not been given any special instructions regarding monitoring of Resident #8. He explained he was not told Resident #8 was restricted to the east unit and thought Resident #8 could go everywhere he wanted to go because he went all over the building by himself. During an interview on 06/27/13 at 2:53 PM with NA #3 she stated the nurses had not told her about any restrictions related to Resident #8. She explained she heard from the other NA's that Resident #8 was not supposed to go on the west unit. She further stated Resident #8 was very independent and went wherever he wanted to during the day. During an interview on 06/25/13 at 3:52 PM with Nurse #12 she stated she thought they were supposed to monitor Resident #8 because he was not supposed to be on the west unit but she was not aware if these restrictions were addressed in Resident #8's care plans.	F 279		

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F 279	Continued From page 22 During an interview on 06/28/13 at 7:41 AM the Unit Manager explained care plans were a multidisciplinary process. He explained he remembered an incident that occurred with Resident #8 and he was then not to go past the vending machine and onto the west unit and was to be monitored. He stated this should have been documented as an intervention in the care plan because if not then staff would not know to monitor him. During an interview on 06/28/13 at 3:56 PM the Administrator explained the monitoring of Resident #8 was an intervention that was shared by word of mouth among the nurses and nurse aides during shift report. She stated it should have been documented as an intervention on Resident #8's care plan so everyone would provide the same monitoring of Resident #8.	F 279		
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	F 280	F280 **How the corrective action will be accomplished for the resident(s) affected** Care Plans were updated to ensure that current interventions for ADLS, fall, and Activities were in place for resident #3 and #6 by the Interdisciplinary Team (IDT).	7/26/13

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F 280	Continued From page 23 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to update the care plan interventions as changes occurred for 2 of 3 sampled residents. Resident #3's care plans were not revised for activities of daily living skills, falls or activities and Resident #6's care plans were not revised for falls or activities. The findings included: 1. Resident #3 was admitted to the facility on 03/13/13 with diagnoses including Alzheimer's type dementia with behavioral disturbances, major depressive disorder, generalized anxiety disorder, coronary artery disease, hypothyroidism, and hyperlipidemia. A care plan developed 03/20/13 which addressed the problem of Resident #3 being at risk for falls had the goal of no fall related injury through next review. Interventions included keeping most used items near resident, encourage frequent rest periods, ask/encourage/assist resident to toilet, keep call bell in place, educate resident to rise slowly to prevent a sudden dropping blood pressure, promote adequate hydration, monitor for adverse reaction to medications, educate resident to tell health care professionals if feeling dizzy, off balance, weak, etc., keep environment free of potential obstacles, wear well fitting shoes	F 280	**How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Nurses were educated on the documentation of interventions for falls, ADLs, and Activities on Care Plans by the Administrator and the Nurse Consultant with completion July 26, 2013. **Measures in place to ensure practices will not occur.** Care Plans have been updated with the intervention(s) for falls, ADLs, and Activities. Nursing staff have been re-educated by IDON and the QI Nurse on falls and documentation of new interventions on July 23, 2013 **How the facility plans to monitor and ensure correction is achieved and sustained.** During weekly Risk meeting, the IDT will check care plans of each fall, ADLs, and Activities to ensure that care plans have been updated and RP and MD notification completed. Audit tool to be completed at that time by the IDT and submitted to Administrator to be presented to the QA Committee for 3 months, then quarterly x 3 for review and revision as needed to ensure compliance	

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	345418	A. BUILDING _____ B. WING _____	C 06/28/2013

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F 280	Continued From page 24 or nonskid socks, assistive devices as needed, keep wheels on bed locked, encourage involvement in activities, vital signs as ordered and as needed. A care plan addressing the inability to complete activities of daily living tasks (transfers, walking, dressing, etc) for Resident #3 included a goal and interventions for the resident to be well groomed and dressed appropriately. A care plan addressing the potential for Resident #3 to have decreased socialization due to cognitive deficits included the interventions for staff to talk to resident during care, and for activity staff to provide tactile stimulation, auditory stimulation and visual stimulation. Per an incident report, on 04/17/13 at 7:50 PM Resident #3 fell from the bed to the floor. The post fall assessment revealed a section that listed applicable interventions initiated in response to the fall and added to the care plan. Post fall interventions listed included provide ambulation assistance and a bed alarm for safety. The care plan was not updated at this time to include either of these interventions. Per an incident report, on 04/19/13 at 6:15 AM the resident fell from her wheelchair while in the sunroom. A self release seat belt was placed on Resident #3 at that time. Post fall interventions included a pharmacy consult, provide ambulation assistance, a restorative toileting program, and verbal cues. The care plan was not updated at this time to include any of these interventions. Physical therapy discharged Resident #3 on	F 280		

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F 280	Continued From page 25 05/01/13 due to severe cognition and being unable to follow through with teaching. It was determined she was high risk for falls and was safer in a wheelchair. The discharge note stated restorative nursing had been educated in ambulation. The care plan was updated on 05/01/13 with the intervention of a self releasing seat belt which Resident #3 removed at will. And on 05/06/13 the care plan was updated to include a bed alarm to remind resident not to get up without assistance and to alert staff that the resident has risen from the bed. The care plans were not updated at this time to include the ambulation restorative program, the resident's use of a wheelchair for safety or a restorative toileting program. Per an incident report, on 05/08/13 at 3:00 PM Resident #3 was placed in bed after lunch and then found on the floor in her room sitting on her buttocks. The nursing note stated the alarm had activated. Interventions per the post fall assessment to be added to the care plan included pharmacy consult, ambulation assistance, restorative toileting and verbal cues. The care plan was not updated. Per an incident report, on 05/09/13 at 6:45 PM Resident #3 was observed on the floor in her room on the side of the bed, kneeling on the floor mat with the alarm sounding. Interventions post fall to be added to the care plan included pharmacy consult, provide ambulation assistance, restorative toileting, verbal cues. The care plan was not updated. Per an incident report, on 05/11/13 at 10:30 AM	F 280		

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F 280	Continued From page 26 resident was found on the floor in front of her wheelchair in the sunroom with her alarm going off. Resident #3 was noted with bruising and a skin tear to her right elbow. The post fall interventions included pain management and assessment, activities consult for increased stimulation, redirect and provide diversional activity, relocate to high visibility area, family involvement and educate resident regarding calling for assistance. The activity care plan was not updated with any additional or specific interventions for Resident #3. Per an incident report, on 05/14/13 at 10:00 AM Resident #3 was observed sitting on the floor on her buttocks in the sunroom in front of the wheelchair. Post fall interventions included pain management, activities consult for increased stimulation, redirect and provide diversional activities, relocate to high visibility area, family involvement and educate resident regarding using call bell for assistance. The activity care plan was not updated with any additional or specific interventions for Resident #3. Per an incident report, on 05/15/13 at 3:45 PM Resident #3 was witnessed in the hall removing her self release lap belt and standing up. Before the nurse aide could reach her, Resident #3 staggered backwards and sat on the floor. Some redness was noted to buttocks and left elbow. Post fall assessment included activities consult for increased stimulation and redirect and provide diversional activities. The activity care plan was not updated with any additional or specific interventions for Resident #3. The care plan was updated on 05/17/13 to	F 280		

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F 280	Continued From page 27 include the use of a lap buddy to the wheelchair at all times when the resident is up. Per an incident report, on 06/25/13 at 6:05 PM Resident was in the hallway and self released her seat belt and attempted to stand and slid to the floor, sitting on her buttocks. The post fall assessment included interventions of provide ambulation assistance, redirections and provide diversional activities, and relocate to a high visible area. There were no updates to the care plan regarding any ambulation assistance or program or any changes to the activity plan. The sunroom was located in the upper end of the hallway and contained a large television, table for dining and large windows between the hall and the sunroom. Resident #3 was observed in a wheelchair with a self release alarmed belt in place on 06/26/13 at 9:59 AM, 10:23 AM and 10:49 AM. The seat belt was noted to be very loose around her waist. There were other residents in this room at the time but no activities and the television was off. On 06/27/13 at 8:36 AM Resident #3 was in the dining room with a nurse aide instructor. She had three alarms in place in her wheelchair. She had a clip on alarm which was not clipped, a seat belt alarm that was not turned on and a pressure pad on the seat which was on. A dycem (non skid) pad was half hanging out of the cushion in her wheelchair. The seat belt was noted to be very loose around her waist. The resident wheeled herself to the hall and sat while various staff stopped an spoke to her but never checked her alarms. At 9:57 Nurse #1 took her to sit by the medication cart as she administered medications.	F 280		

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F 280	Continued From page 28	F 280		

At this time, Nurse #1 was informed of the alarms not all being on and she attached them. Nurse #1 stated the facility had tried a lap buddy but that agitated her and she threw it on the floor. Per Nurse #1 if the seat belt was too tight around her waist, Resident #3 got very agitated and removed it. When asked about the three alarms and how staff were to know what the current alarm usage was, Nurse #1 stated there was a lack of communication when devices are added or changed. Devices just showed up. She thought the nurse aides would know via the computer system they use for documentation purposes.

On 06/27/13 at 3:52 PM Nurse Aide (NA) #3 stated she will walk with the resident but she shuffled and her knees bothered her. NA #3 stated devices had included a tab alarm which she removed, a chair pad alarm and a lap strap. To prevent falls, NA #3 stated they tried to keep a close eye on Resident #3, routinely took her to the bathroom before and after meals, and tried to send her to activities.

On 06/28/13 at 2:50 PM NA #4 stated to prevent Resident #3 from falling, she gave her things to do with her hands, told her the lap belt looked beautiful, and took her with the NA to do charting. NA #4 stated she was unaware of any ambulation program and stated Resident #3 could not walk.

On 06/28/13 at 3:42 PM an interview was conducted with the Administrator and Regional Nurse Consultant. The Administrator stated that falls were discussed in morning meetings. She stated the staff discussed the specifics of the fall, any changes in environment and each department added any options or interventions

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F 280	Continued From page 29	F 280		

they thought would prevent falls. Any thing that was discussed would be left to the department head to follow thorough and added to the care plan. Per the administrator, the planned interventions on the post fall assessments were in progress and trials. She stated redirection was an ongoing interventions, ambulation assistance was just to assist as necessary, restorative toileting was not necessarily a planned program. The Administrator could not be specific as to what specific interventions were initiated and implemented by each department after discussing each fall. She could not say what each post fall assessment intervention entailed or how staff were to know what was to be provided for the resident.

On 06/28/13 at 6:32 PM, a telephone interview with the MDS nurse stated this resident had a significant change and could no longer walk. She stated she thought she updated the care plan for ADLs to reflect this change.

2. Resident #6 was admitted to the facility on 02/13/13, then was hospitalized on 02/17/13 and readmitted to the facility on 03/11/13. Her diagnoses included delirium, dementia, depression, atrial fibrillation, coronary artery disease, and chronic obstructive pulmonary disease.

A care plan was developed 03/11/13 which addressed Resident #6 being at risk for falls due to removing her bed alarm and trying to get out of bed without assistance. The goal was for the resident to have no fall related injuries. Interventions included educating the resident to tell health care professionals if feeling dizzy, off

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balance, weak, etc, monitoring for adverse reactions to medications, educating the resident to rise slowly to prevent a sudden drop in blood pressure, promote adequate hydration, keep environment free of obstacles, encourage involvement in activities, vital signs as ordered and as needed, keep wheels on bed locked, wear well fitting shoes and or nonskid socks when ambulating, assistive devices ad needed, keep call bell in place, keep most used items near resident, encourage frequent rest periods, and ask/encourage/assist resident to toilet. A care plan developed on 03/21/13 for potential for decreased socialization due to cognitive deficits included interventions for staff to talk with resident during care, provide items for sensory stimulation, provide tactile stimulation, auditory stimulation and visual stimulation.

The care plan relating to falls was updated on 03/22/13 with the addition of a removable seat belt at all times while the resident was in the wheelchair. The resident was able to remove it.

Per an incident report, on 05/09/13 at 12:00 PM Resident #6 was in her room, unhooked her seat belt, stood, fell and hit her head on the door. The alarm on the seat belt did not sound. The post fall assessment revealed a section that listed applicable interventions initiated in response to the fall and added to the care plan. Post fall interventions included redirect and provide diversional activity. There was no change to the activity care plan.

Per an incident report on 05/09/13 at 8:45 PM Resident #6 was observed on the floor in her room sitting on the floor mat with no alarms

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F 280	Continued From page 31 sounding. The alarm had been on but the cord was so long it didn't disconnect and sound. Post fall interventions included redirect and provide diversional activity. There was no change to the activity care plan. Per an incident report on 05/14/13 at 3:30 AM a nurse aide observed the resident sliding off the edge of the bed but could not reach the resident in time to prevent her from hitting the floor. The incident report noted the resident had removed the alarm. The corresponding nursing note dated 05/14/13 at 4:41 AM stated the resident had removed the alarm which she had a recurrent history of doing and she was not wearing shoes or socks. The interventions listed on the post fall assessment included redirect and provide diversional activities. There was no change to the activity care plan. Per an incident report on 05/19/13 at 6:20 AM staff heard Resident #6 calling out and found her in the bathroom on her knees facing the toilet. The mobility alarm was not clipped to her clothing and she had bare feet. The corresponding nursing note dated 05/19/13 at 7:44 PM stated the mobility alarm was lying on the bed where she apparently unfastened it. The listed post fall interventions included to redirect and provide diversional activities. There was no change to the activity care plan. Per an incident report on 06/06/13 at 7:45 AM Resident #6 was found in the sunroom lying on her back and complaining about her head and right elbow. A bruise was forming on her elbow and she was sent tot he emergency room for treatment. The incident report mentioned the seat	F 280		

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F 280	Continued From page 32 belt alarm was repaired. The post fall assessment interventions was to redirect and provide diversional activities. There was no change to the activity care plan. The fall care plan was updated on 06/19/13 to discontinue the resident education to rise slowly, to discontinue vital signs as ordered and prn, to discontinue the assistive devices as needed all noting the reason of the discontinuation due to "resolved." In addition the intervention of the seat belt alarm at all times was discontinued on 06/19/13 noting the reason was it was entered in error and a chair alarm was to be used when resident was in the wheelchair with a start date of 06/25/13. The activity care plan was not changed to reflect any additional interventions or plans to provide diversional activities. On 06/26/13 at 9:51 AM Resident #6's bed was observed with a tab/clip type alarm on the right turn rail. On 06/26/13 at 9:54 AM, Resident #6 was observed in the sunroom with a very loose alarmed seat belt in place, Resident #6 released the seat belt multiple times sounding the alarm. Staff responded each time and refastened the seat belt but provided no diversional activities until she was taken to the activity room at 10:12 AM by the Administrator. There was no television or any activities going on at this time. On 06/27/13 from 8:39 AM through 9:40 AM, Resident #6 propelled her wheelchair from the sunroom to the hall with no diversional activities in place.	F 280		

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F 280	Continued From page 33 Interview on 06/27/13 at 3:59 PM with Nurse Aide (NA) #3 revealed Resident #6 often removed her alarmed seat belt. NA #3 stated activity department gave her laundry to fold and staff tried to hide the belt. According to NA #3 the resident had never been ambulatory but can stand and pivot. NA #3 stated Resident #6 will go to some music groups and staff try to keep an eye on her the best they can. Interview on 06/27/13 at 5:24 PM with NA #5 revealed interventions used to prevent Resident #6 from falling included her alarmed seat belt and keeping an eye on her. He further stated the resident liked to talk. Interview with NA #4 on 06/28/13 at 2:54 PM revealed she gave Resident #6 laundry to fold as she liked to do things with her hands in order to prevent falls. NA #4 stated Resident #6 was hard to redirect. On 06/28/13 at 3:42 PM an interview was conducted with the Administrator and Regional Nurse Consultant. The Administrator stated that falls were discussed in morning meetings. That the staff discuss the specifics of the fall, any changes in environment and each department added any options or interventions they think would prevent falls. Anything that was discussed would be left to the department head to follow through and add to the care plan. Per the administrator, the planned interventions on the post fall assessments were in progress and trials. She stated redirection was an ongoing interventions, ambulation assistance was just to assist as necessary, restorative toileting was not necessarily a planned program. Any intervention	F 280		

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F 280	Continued From page 34 that any department head wanted to implement would be up to the department head to place on the care plan. The Administrator could not be specific as to what specific interventions were initiated and implemented by each department after discussing each fall. She also stated that the alarm was meant for any type of an alarm and not specific to a pressure type or clip type. She could not say what each post fall assessment intervention entailed or how staff were to know what was to be provided for the resident.	F 280		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to provide showers as scheduled twice a week for 3 of 3 sampled residents. (Resident #3, #6, #17). The findings included: 1. Resident #6 was admitted to the facility on 02/13/13, then was hospitalized on 02/17/13 and readmitted to the facility on 03/11/13. Her diagnoses included delirium, dementia, depression, atrial fibrillation, coronary artery disease, and chronic obstructive pulmonary disease.	F 312	F312 **How the corrective action will be accomplished for the resident(s) affected.** Resident # 3, #6, #17 were given showers by 6/27/13. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Shower schedules were updated to ensure showers are twice a week. CNA's were given a shower sheet to indicate the days and shifts responsible for the showers. If the patient refuses, they must get a nurse to verify refusal and the nurse will place a note in the progress note regarding the refusal. Residents will be asked upon admission their choice for how often they would like to shower.	7/26/13

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F 312	Continued From page 35 The admission Minimum data Set (MDS) dated 03/18/13 coded her as having severely impaired cognitive skills, having verbal and physical behaviors and rejecting care and requiring extensive assistance with bed mobility, transfers and bathing. A care plan was developed on 03/22/13 to address the inability of Resident #6 to complete activities of daily living (ADL) tasks. Interventions included to assist the resident to shower twice a week. Review of the ADL Data Report, completed by nursing assistants, revealed Resident #3 did not receive a shower from 05/31/13 through 06/05/13 (6 days) and from 06/21/13 through 06/26/13 (6 days). On 06/26/13 at 2:08 PM, Nurse #1 stated showers were not getting completed due to short staffing. She further stated when it has been reported to her that staff can't complete showers, she has told the nurse aides to do the best they can and Nurse #1 tried to prioritize what care and what resident would be most important not to skip. Nurse Aide (NA) # 3 stated on 06/27/13 at 2:53 PM that staffing has been short for the last month or so. She stated if showers cannot be completed then they try to give good bed baths and make up the shower on the next day or wait until the next shower day. NA #9 stated on 06/27/13 at 5:31 PM that showers were difficult to complete as scheduled due to staffing. She stated that staff reported this	F 312	**Measures in place to ensure practices will not occur.** CNA's were educated on ADL documentation and notification of refusals by patients by the prior administrator and completed on 7/26/13. The 3-11 Supervisor will collect the Daily Shower sheets and ensure that all patients received their shower. If a refusal is documented on the sheet, the supervisor is to check and ensure that a progress note was documented by the nurse. Deviations may result in disciplinary action. Manager on Duty (MOD) will monitor showers completion on their assignment checklist. **How the facility plans to monitor and ensure correction is achieved and sustained.** Shower sheets and MOD checklist are to be given to the prior Administrator to be reviewed weekly and submitted to the QA Committee for 3 months, then quarterly x 3 for review and revision as needed to ensure compliance.	

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ASHEVILLE HEALTH CARE CENTER	1984 HIGHWAY 70 SWANNANOA, NC 28778

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F 312	Continued From page 36 to the nurses who stated that a bed bath was acceptable. On 06/28/13 at 10:10 AM, NA #4 stated due to short staffing, showers were not always completed twice a week. Staff tried to make a missed shower up the next day as able. Interview with the administrator on 06/28/13 at 4:55 PM revealed if a nurse aide could not do a shower for some reason, the nurse aide should ask he resident if it would be alright to make it up the next day or pass it off to the next shift to complete. She further stated she was unaware showers were not being given as scheduled. 2. Resident #3 was admitted to the facility on 03/13/13 with diagnoses including Alzheimer's type dementia with behavioral disturbances, major depressive disorder, generalized anxiety disorder, coronary artery disease, hypothyroidism, and hyperlipidemia. The admission Minimum Data Set (MDS) dated 03/20/13 coded her with severely impaired cognitive skills, and requiring supervision with bed mobility, transfers, and walking and requiring physical help with bathing. A care plan was developed on 03/26/13 which addressed her inability to complete activities of daily living (ADL) tasks . Interventions included to assist the resident to shower twice a week. Review of the ADL Data Report, completed by nursing assistants, revealed Resident #3 did not receive a shower on 04/02/13 through 04/07/13 (6 days) and again from 04/16/13 through	F 312		

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F 312	Continued From page 37 04/21/13 (6 days). On 06/26/13 at 2:08 PM, Nurse #1 stated showers were not getting completed due to short staffing. She further stated when it has been reported to her that staff can't complete showers, she has told the nurse aides to do the best they can and Nurse #1 ties to prioritize what care and what resident would be most important not to skip. Nurse Aide (NA) # 3 stated on 06/27/13 at 2:53 PM that staffing has been short for the last month or so. She stated if showers cannot be completed then they try to give good bed baths and make up the shower on the next day or wait until the next shower day. NA #9 stated on 06/27/13 at 5:31 PM stated that showers are difficult to complete as scheduled due to staffing. She stated that staff report this to the nurses who stated that a bed bath was acceptable. On 06/28/13 at 10:10 AM, NA #4 stated due to short staffing, showers were not always completed twice a week. Staff tried to make a missed shower up the next day as able. Interview with the administrator on 06/28/13 at 4:55 PM revealed if a nurse aide could not do a shower for some reason, the nurse aide should ask he resident if it would be alright to make it up the next day or pass it off to the next shift to complete. She further stated she was unaware showers were not being given as scheduled.	F 312		

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F 312	Continued From page 38 3. Resident #17 was admitted to the facility on 03/19/13 with diagnoses which included multiple sclerosis, osteoporosis, muscle weakness and depression. The most recent quarterly Minimum Data dated 06/28/13 indicated Resident #17 was cognitively intact for daily decision making and required extensive assistance with hygiene and was totally dependent on staff for bathing. A review of care plans dated 04/01/13 indicated a problem statement that Resident #17 was unable to complete tasks related to personal care. The goals indicated Resident #17 will be well groomed and dressed appropriately and activities of daily living tasks will be addressed through next review date of 04/03/13. The approaches on the care plan were listed in part to provide assistance with personal hygiene and grooming needs as needed and assist resident to shower twice a week. A review of a shower schedule indicated Resident #17 was scheduled for a shower on Tuesday and Friday of each week on second shift between 3:00 PM and 11:00 PM. A review of The ADL Data Report, completed by nursing assistants, revealed Resident #17 did not receive a shower from 04/28/13 through 05/03/13 (5 days), from 05/08/13 through 05/13/13 (6 days), from 05/19/13 through 05/23/13 (5 days) and from 06/23/13 through 06/27/13 when she got a shower during the survey. During an observation on 06/27/13 at 9:51 AM Resident #17 was lying in bed in her room dressed in a gown and her hair was uncombed	F 312		

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F 312	Continued From page 39 and oily and there was a sour odor. During an interview on 06/27/13 at 9:52 AM Resident #17 stated she hasn't had a shower or had her hair washed since last Saturday. She explained she missed her shower last Friday evening. She further stated she was told she would get a shower on the 3:00 PM to 11:00 PM shift on Tuesday night but she didn't get it. During an interview on 06/27/13 at 10:24 AM with NA #10 she confirmed Resident #17 was on the second shift shower schedule. She stated Resident #17 told her this morning that she hadn't had a shower since last Saturday but that was the first time she had heard that. NA #10 explained Resident #17 had to be transferred with a lift with 2 staff when she went for her shower. During an interview on 06/27/13 at 5:40 PM with NA #5 he explained there was a shower on Tuesday evening that did not get done and confirmed that it was Resident #17's shower. He stated Resident #17's shower was then passed to them last night but they couldn't get it done either. He further stated once a shower got behind it was nearly impossible to catch up. NA #5 stated Resident #17 should have gotten her shower on Tuesday evening and we discussed it in our shift report. He stated Resident #17 required a lift transfer with 2 nurse aides when she received her showers. During an interview on 06/27/13 at 6:03 PM with NA #11 she explained she gave Resident #17 her shower last Saturday because she had missed her shower on Friday. She stated it took a half hour to 45 minutes to give Resident #17 her shower and it took two staff members to transfer	F 312		

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F 312	Continued From page 40 and shower her. During an interview on 06/28/13 at 3:56 PM the Administrator stated it was her expectation that resident's should get a shower when they wanted a shower. She further stated if a shower was missed the NA's should talk with the resident and find out when they wanted their shower done and accommodate the resident's needs. She further stated the NA's should also communicate with the nurse when a resident's shower was missed.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to assess and treat a pressure wound as ordered for 1 of 3 sampled residents (Resident #5). The findings included: Resident #5 was admitted to the facility on 05/01/13 with diagnoses which included peri-rectal cellulitis, wounds to buttocks, morbid obesity, diabetes mellitus, chronic lymphedema	F 314	F314 **How the corrective action will be accomplished for the resident(s) affected.** Resident # 5 Chart was assessed, treatment provided as ordered, and documentation updated **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Current Nursing staff was educated on wound assessments, and documentation by the QI Nurse by 7/26/2013. An audit of all Skin Assessments and Wound Assessment Sheets was completed by the QI Nurse to ensure compliance with the most current physician orders. Wound assessment, Treatments, and skin assessments will be included in all New Nurse orientation.	7/26/13

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F 314	Continued From page 41 and anemia. An admission Minimum Data Set (MDS) was completed on 05/08/13 and assessed Resident #5 as cognitively intact for daily decision making. The MDS indicated the resident required extensive assistance of 2 staff with bed mobility, toilet use, personal hygiene and dressing and was totally dependent on staff for bathing. The resident was non-ambulatory during the observation period. The MDS also indicated Resident #5 was frequently incontinent of urine and always incontinent of bowel. The resident was assessed as having moisture associated skin damage and 9 Stage 2 pressure ulcers. The MDS indicated the following interventions were in place: a pressure reducing device for chair, nutrition or hydration intervention, pressure ulcer care, and applications of ointments/medication. The Care Area Assessment (CAA) Summary addressing pressure ulcers indicated Resident #5 was admitted with multiple Stage 2 ulcers on the buttocks and hips and was at risk for developing additional ulcers due to limited mobility and incontinence of bowel and bladder. The decision was made to proceed to care plan. A care plan dated 05/03/13 addressed skin breakdown and multiple Stage 2 pressure ulcers which were present on admission. Interventions included: treatment as ordered by physician, keep skin clean & dry, assist with turning and positioning every 2 hours, use wedge to help keep on side, float heels when in bed and skin assessment weekly. The care plan was revised on 06/13/13 to	F 314	**Measures in place to ensure practices will not recur.** Charge nurses will review Skin Assessment Sheets and Ulcer and Wound Sheets to be completed each day before the end of the shift. DON/UM/SDC will audit skin assessment books daily and the Treatment Administration Record will be reviewed for documentation of completion of wound care Mon-Fri for two weeks; weekly for two weeks, monthly for 2 months, then quarterly x three to ensure Skin assessments/ Wound measurements and treatments are completed. **How the facility plans to monitor and ensure correction is achieved and sustained.** Audit results will be reported to the QA committee monthly for 3 months, then quarterly x 3 to ensure compliance and revision as needed.	

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F 314	Continued From page 42 address a Stage 3 sacral pressure ulcer. The care plan indicated barrier cream was to be applied to thighs/buttocks daily and to be sure to keep it away from the transparent film dressing. The sacral wound was to be irrigated with saline, packed with silver alginate, covered with foam and secured with a transparent film dressing daily. Additional interventions included a Group 2 alternating pressure air mattress for pressure reduction and wound consult as indicated. The area on the right posterior thigh was described as a Stage 2 diabetic ulcer. A review of the skin and wound assessment records for Resident #5 revealed a document titled Ulcer and Wound Record which was completed on 05/01/13 and noted that resident had multiple (15 - 20) stage II ulcers on right and left buttocks and left upper lateral thigh which varied in size from 10 centimeters (cm) to 30 cm. No specific measurements were listed for each open area except the left thigh which was listed as 11.4 cm long X 2.0 cm wide and described as intact blisters with no drainage; the peri-wound area was described as intact. There were not any measurements between 05/01/13 and 05/18/13. Additional measurements of the left thigh were as follows: 05/18/13 - 4.4 cm long X 2.0 cm wide with serosanguinous drainage and the wound bed had granulation and epithelial tissue, no blisters were indicated; the peri-wound area was intact. 06/05/13 - 4.2 cm long X 2.0 cm wide X 0.7 cm deep with serosanguinous drainage and the wound bed had granulation and epithelial tissue, no blisters were indicated. 06/11/13 - 15.0 cm long X 9.0 cm wide X 0.1 cm deep with serosanguinous drainage and the	F 314		

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F 314	Continued From page 43 wound bed had granulation and epithelial tissue; the peri-wound area was red/inflamed. 06/18/13 - 34.0 cm long X 4.0 cm wide X 0.1 cm deep with serosanguinous drainage and the wound bed had granulation tissue; the peri-wound was red/inflamed. An ulcer and wound record dated 05/08/13 listed the right inner buttocks: 6.2 cm long X 4.0 cm wide X 0.2 cm deep with serosanguinous drainage and wound bed had slough and granulation tissue; the peri-wound was red/inflamed. There were not any measurements between 05/08/13 and 05/23/13. Additional measurements of the right inner buttocks were as follows: 05/23/13 - 6.2 cm long X 4.0 cm wide X 0.2 cm deep 06/05/13 - the area to the right and left inner buttocks was described as merged into one area and the measurements were listed from that date forward under the left inner buttock until 06/18/13 when the location description was changed to sacrum. An ulcer and wound record dated 05/8/13 listed the left inner cheek (buttock): 7.2 cm long X 5.3 cm wide with eschar and the peri-wound was red/inflamed. There were not any measurements between 05/08/13 and 05/23/13. Additional measurements of the left inner buttock were as follows: 05/23/13 - 7.2 cm long X 5.3 cm wide X 0 deep 06/05/13 - 10.5 cm long X 10.3 cm wide x 2.5 cm deep with serosanguinous drainage and the wound bed had eschar and slough; the peri-wound was red/inflamed. 06/11/13 - 9.0 cm long X 7.5 cm wide X 4.5 cm	F 314		

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F 314	Continued From page 44 deep with serosanguinous drainage and the wound bed had eschar and slough; the peri-wound was red/inflamed. 06/18/13 9.0 cm long X 9.0 cm wide X 2.8 cm deep with serosanguinous and purulent drainage; 30% of the wound bed had slough and 70% of the wound bed had granulation tissue; the peri-wound area was red/inflamed. Additional record review revealed the following physician's orders: 05/23/13 Doxycycline 100 milligrams (mg), an antibiotic, twice a day for 10 days for cellulitis of buttocks. 05/24/13 Wound clinic consult as soon as possible. 05/28/13 Change wound care to coccyx as follows: xeroform and cover with viscopaste (a vaseline impregnated gauze); Diflucan, an antifungal medication, 200 mg daily for 14 days. 06/06/13 Bactrim Double Strength, an antibiotic, twice a day for 10 days. 06/12/13 0.25% Dakin's solution wet to dry with 4 X 4 gauze to sacral ulcer twice a day for 2 weeks; Extra Protective cream to right posterior thigh every day for 2 weeks; follow up with Wound Center in 2 weeks. 06/13/13 Diflucan 100 mg daily for 14 days. Review of physician's progress notes revealed documentation of the following visits: On 05/23/13 Resident #5 was seen because of staff's concerns about a lesion on her buttock area. The note indicated the area appeared to be a skin tear which he felt was possibly from shear and he did not feel it was due to a pressure area. The note indicated the lesions appeared to be	F 314		

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F 314	Continued From page 45 developing infection. The plan was to treat her with Doxycycline 100 mg BID for 10 days. On 05/28/13 Resident #5 was seen again to assess her buttock wound and the note indicated the wound was improving and the resident was on an air mattress. On 06/04/13 Resident #5 was seen for assessment of sacral wound. The area was assessed as slowly improving and the physician felt the resident needed an indwelling catheter due to incontinence and the need to minimize contamination of the wound and promote wound healing. On 06/05/13 Resident #5 was seen for evaluation of sacral wound. The note indicated the right buttock wound was open and had eschar. No purulent drainage was noted. The resident also had a wound on the left hip. The assessment and plan was that Resident #5 had a decubitus to both buttocks and was to be referred to the wound center as soon as possible for debridement. The planned treatment was to use Santyl for chemical debridement of the decubitus and viscopaste to her left leg. He also planned to place her on Bactrim Double Strength twice daily for 10 days. A review of the May and June 2013 Treatment Administration (TAR) records for Resident #5 revealed the following documentation: An air mattress with a pump was documented as being on Resident #5's bed beginning 05/28/13. Extra protective cream to buttocks covered with viscopaste strips twice daily was documented as started 05/01/13 and discontinued 06/06/13 - there were 35 instances when it was not	F 314		

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F 314	Continued From page 46 documented as done. Xeroform dressing covered with viscopaste strips twice daily was documented as started 05/28/13 and discontinued 06/06/13 but was not documented as done on 05/28/13, on 05/29/13 at 5:00 PM, on 05/30/13 at 9:00 AM; it was not documented as done at all from 05/31/13 through 06/03/13, on 06/04/13 at 9:00 AM; and it was not documented as done at all on 06/05/13 or 06/06/13. Santyl ointment to coccyx daily was documented beginning 06/06/13 through 06/12/13 but was only documented as done on 06/09/13 and 06/12/13. Dakin's 0.25% solution apply twice daily topical for wound was documented as started 06/12/13 and discontinued 06/25/13 but was not documented as done at all on 06/13/13 through 06/15/13, on 06/18/13 at 9:00 PM, on 06/21/13 at 9:00 AM, on 06/22/13 at 9:00 AM or on 06/23/13 at 9:00 PM. Irrigate sacral wound with saline, pack with silver alginate, cover with foam, secure with transparent dressing daily was documented beginning 06/26/13. A group 3 air fluidized mattress for stage 3 pressure ulcer was documented as started on 06/18/13. A wound culture report dated 05/23/13 revealed the culture was positive for proteus mirabilis and klebsiella pneumoniae.	F 314		

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F 314	Continued From page 47 Review of records from the local Wound Healing & Hyperbaric Center Note of Initial Examination on 06/11/13 indicated resident was evaluated for a sacral decubitus which had been present for approximately 1 month. The area measured 9.0 cm X 7.5 cm X 4.5 cm. The note described the wound as having a large amount of serosanguinous and malodorous exudate. The pressure ulcer bed had exposed subcutaneous tissue and the skin around the pressure ulcer was erythematous. The recommendation for treatment was to apply 1/4 % Dakin's wet to dry and 4 X 4 gauze twice daily for 2 weeks and the resident was to be seen again at the Clinic in 2 weeks. The note also indicated a large necrotic flap was removed with forceps and a culture was obtained. The area was assessed as being due to pressure and the wound clinic requested confirmation that the resident was on a Group 2 bed surface and information on the duration of it's use. The pressure area on Resident #5's thigh was assessed as being due to diabetes. An observation on 06/26/13 at 2:35 PM of Nurse #7 providing treatment to the pressure ulcer on the sacrum revealed no dressing was in place over the wound when the nurse started the treatment. Nurse #7 asked Nurse Aide (NA)#7 when the dressing came off and the NA stated it came off earlier when she changed her. The pressure ulcer was on the inner aspect of both buttocks and extended across the sacrum. The area was approximately 10 centimeters(cm) long by 10 cm wide with a depth of approximately 3 cm. Subcutaneous tissue was visible & there was bloody drainage present. An interview on 06/26/13 at 3:00 PM with NA #6, who was assigned to provide care for Resident	F 314		

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F 314	Continued From page 48 #7 revealed the resident was provided incontinence care about 1:00 PM after she had a bowel movement and the dressing to the sacral ulcer came off then. She stated she didn't tell the nurse but thought the other NA might have. She stated they are expected to notify the nurse if the dressing is off. She stated the resident had another incontinent bowel movement between 1:00 PM and the time the dressing was changed at 2:35 PM. An interview on 06/26/13 at 3:05 PM with Nurse #7 about the dressing not being in place to Resident #5's sacrum revealed she had not been informed by the NAs that the dressing came off while they were providing incontinence care. Nurse #7 stated that she would have expected the NAs to notify her that the dressing was off. An interview on 06/26/13 at 3:10 PM with NA #7 revealed she didn't notify the nurse the dressing was off because she knew the nurse was coming in to do the treatment. She stated she was supposed to notify the nurse if the dressing was off. An interview on 06/26/13 at 3:35 PM with Nurse #1 revealed the nurses weren't doing the treatments as ordered for Resident #5 because there weren't enough NAs to assist with repositioning the resident so the nurse could do the treatment. Nurse #1 stated a specialty mattress was not placed on Resident #5's bed until 05/24/13. Nurse #1 also stated wound measurements weren't being done every week as they should be. An interview on 06/26/13 at 5:02 PM with Nurse	F 314		

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	345418	A. BUILDING _____ B. WING _____	C 06/28/2013

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F 314	Continued From page 49 #2 revealed the nurses are responsible for doing all the treatments as well as administering medications. Nurse #2 stated just administering the medications often takes all shift so the nurses aren't consistently getting the treatments done because there isn't enough time. An interview on 06/27/13 at 5:30 PM with the physician about Resident #5's wounds revealed he was asked to see the resident on 05/23/13 to assess skin breakdown on the buttocks. He stated he saw the resident again on 05/25/13 and asked staff to get an air mattress for the resident. He stated he examined Resident #5's wound on the buttocks on 05/28/13 and thought it was getting better. He stated he looked at the wound on Resident #5's buttocks again on 06/06/13 and the area was much worse; at that point the wound had eschar and he referred the resident to the Wound Clinic as soon as possible for debridement. The physician was asked about his expectation for measuring and monitoring of wounds and he stated the nurses should be measuring and monitoring the areas. An interview on 06/28/13 at 11:15 AM with the Regional Nurse Consultant about the expectation for assessment of open wounds revealed that all open wounds should be assessed weekly and the assessment should include measurements of the wound. When asked if there were any additional measurements of Resident # 5's wounds, he stated the facility was unable to locate any wound measurements done between 05/08/13 and 05/23/13. He stated his expectation was for all wounds to be assessed and measured every week whether they were due to pressure or not.	F 314		
F 323	483.25(h) FREE OF ACCIDENT	F 323		7/26/13

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F 323 SS=E	Continued From page 50 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, record reviews, and staff interviews, the facility failed to determine the reasons for falls and implement coordinating interventions to prevent further falls for 3 of 3 sampled residents. (Residents #3, #6 and #17). The findings included: 1. Resident #3 was admitted to the facility on 03/13/13 with diagnoses including Alzheimer's type dementia with behavioral disturbances, major depressive disorder, generalized anxiety disorder, coronary artery disease, hypothyroidism, and hyperlipidemia. The admission Minimum Data Set (MDS) dated 03/20/13 coded her with severely impaired cognitive skills, and requiring supervision with bed mobility, transfers, and walking. She was coded as being steady with balance at all times. She had wandering behaviors 4 to 6 days, but less than daily. She was coded as having no falls prior to admission or since admission. The Care Area Assessment (CAA) dated 03/26/13 stated Resident #3 was at risk for fall	F 323	F323 **How the corrective action will be accomplished for the resident(s) affected.** Resident # 3 will be screened by therapy for appropriate positioning device usage and for a Toileting Plan before and after meals, as well as Activities in place for Resident #3. Resident #6 seat belt alarm was checked and worked; and the alarm cord was checked for appropriate length and type as described on the Care Plan and was attached to the resident and functional. Residents #3 and #6 were each assessed for appropriate intervention which were added to the care plan. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Nursing and Administrative Staff will be re-educated by the QI Nurse by 7/26/13.on devices and the device list. The Interdisciplinary Team (IDT), the Administrator, and newly hired employees will be educated on devices and the device list.	7/26/13

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F 323	Continued From page 51 related injuries due to her use of psychotropic medication and severe cognitive impairment resulting in poor safety awareness. The CAA stated a care plan would be developed to prevent fall related injuries. A care plan developed 03/20/13 which addressed the problem of Resident #3 being at risk for falls had the goal of no fall related injury through next review. Interventions included keeping most used items near resident, encourage frequent rest periods, ask/encourage/assist resident to toilet, keep call bell in place, educate resident to rise slowly to prevent a sudden dropping blood pressure, promote adequate hydration, monitor for adverse reaction to medications, educate resident to tell health care professionals if feeling dizzy, off balance, weak, etc., keep environment free of potential obstacles, wear well fitting shoes or nonskid socks, assistive devices as needed, keep wheels on bed locked, encourage involvement in activities, vital signs as ordered and as needed. Physical therapy was started on 04/04/13 due to her exhibiting a shuffling gait with ambulation. Review of the incident reports revealed the following falls: *04/17/13 at 7:50 PM the nurse was passing medication, heard a loud bang and found resident sitting on the floor with her head resting on the door. It was noted Resident #3 was resting in bed earlier. The post fall assessment revealed a section that listed applicable interventions initiated in response to the fall and added to the care plan. Post fall interventions listed included	F 323	**Measures in place to ensure practices will not occur.** A device list for all residents will be provided to the Nursing and Administrative Staff for daily auditing of devices. All residents with devices have been review for appropriateness, type, and the care plan updated. The device list will be updated as needed during fall review. The Interdisciplinary Team (IDT) and the Administrator will review falls during Stand-Up on the next business day to determine the cause of the fall. IDON/UM will update the device list and the care plan. Any deviations will be addressed at that time. **How the facility plans to monitor and ensure correction is achieved and sustained.** The IDON/ Administrator will report results to the QA Committee monthly x 3, then quarterly x 3 for continue compliance or revisions to the plan as needed.	

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F 323	Continued From page 52 provide ambulation assistance, bed alarm for safety. The nursing notes dated 04/17/13 at 10:04 PM noted a pressure sensitive alarm was applied for safety. *04/19/13 at 6:15 AM she was in the sunroom and was observed sitting on the floor in front of her wheelchair. A self release seat belt was placed on Resident #3 at that time. Post fall interventions included a pharmacy consult, provide ambulation assistance, a restorative toileting program, and verbal cues. There was no evidence in the medical record that an ambulation program or toileting program was initiated. A significant change MDS dated 04/25/13 coded Resident #3 with severely impaired cognitive skills, having no behaviors, and requiring extensive assistance with bed mobility, transfers, and limited assistance with ambulation. It was noted she was not steady but able to stabilize herself without help when walking and turning around but needed staff assistance to stabilize when moving from seated to standing position, moving on and off toilet and surface to surface transfers. It was coded that she had falls since prior assessment including one with no injury and one with minor injury. The CAA dated 04/30/13 stated she was at risk for fall related injuries due to her use of psychotropic medications and sever cognitive impairment resulting in poor safety awareness. She had 2 falls and had declined physically resulting in a shuffling gait and had been transitioned to a wheelchair for safety as she was no longer able to use her walker. Physical therapy discharged Resident #3 on 05/01/13 due to severe cognition and being	F 323		

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F 323	Continued From page 53 unable to follow through with teaching. It was determined she was high risk for falls and was safer in a wheelchair. The discharge note stated restorative nursing had been educated in ambulation. There was no evidence in the medical record of a restorative ambulation program for Resident #3. The care plan was updated on 05/01/13 with the intervention of a self releasing seat belt which Resident #3 removed at will. And on 05/06/13 the care plan was updated to include a bed alarm to remind resident not to get up without assistance and to alert staff that the resident has risen form the bed. Resident #3 continued to fall as evidenced by the following incident reports: *05/08/13 at 3:00 PM Resident #3 was placed in bed after lunch and then found on the floor in her room sitting on her buttocks. The accompanying nursing note dated 05/08/13 7-3 PM stated when staff left resident her bed alarm was active and on and staff later walked by to find resident on the floor by the doorway and her alarm going off. Interventions per the post fall assessment to be added to the care plan included pharmacy consult, ambulation assistance, restorative toileting and verbal cues. There was no evidence of a restorative toileting program. *05/09/13 at 6:45 PM Resident #3 was observed on the floor in her room on the side of the bed, kneeling on the floor mat with the alarm sounding. Interventions post fall to be added to the care plan included pharmacy consult, provide ambulation assistance, restorative toileting,	F 323		

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F 323	Continued From page 54 verbal cues. There was no evidence of a restorative toileting program. *05/11/13 at 10:30 AM resident was found on the floor in front of her wheelchair in the sunroom with her alarm going off. Resident #3 was noted with bruising and a skin tear to her right elbow. The post fall interventions included pain management and assessment, activities consult for increased stimulation, redirect and provide diversional activity, relocate to high visibility area, family involvement and educate resident regarding calling for assistance. There was no evidence of any changes in the activity plan for Resident #3. The activity participation record for 05/09/13 through 05/12/13 showed no documentation of any activities involving Resident #3. On 05/13/13 and 05/14/13 there was only one 1:1 each day. *05/14/13 at 10:00 AM Resident #3 observed sitting on the floor on her buttocks in the sunroom in front of the wheelchair. Post fall interventions included pain management, activities consult for increased stimulation, redirect and provide diversional activities, relocate to high visibility area, family involvement and educate resident regarding using call bell for assistance. *05/15/13 at 3:45 PM Resident #3 was witnessed in the hall removing her self release lap belt and standing up. Before the nurse aide could reach her, Resident #3 staggered backwards and sat on the floor. Some redness was noted to buttocks and left elbow. Post fall assessment included activities consult for increased stimulation and redirect and provide diversional activities.	F 323		

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F 323	Continued From page 55 The care plan was updated on 05/17/13 to include the use of a lap buddy to the wheelchair at all times when he resident is up. Review of the activity participation record for 05/15/13 through 05/31/13 revealed she attended/was provided activities less than daily. There was nothing documented by activity staff for Resident #3 for 7 days during this period. Between 06/01/13 and 06/25/13 there were 10 days without any documented activities. Another fall occurred on: *06/25/13 at 6:05 PM Resident was in the hallway and self released her seat belt and attempted to stand and slid to the floor, sitting on her buttocks. The post fall assessment included interventions of provide ambulation assistance, redirections and provide diversional activities, and to relocate the resident to a high visible area. The nursing notes dated 06/25/13 at 6:24 PM noted the resident's fall was witnessed by another alert and oriented resident. The sunroom was located in the upper end of the hallway and contained a large television, table for dining and large windows between the hall and the sunroom. Resident #3 was observed in a wheelchair with a self release alarmed belt in place on 06/26/13 at 9:59 AM, 10:23 AM and 10:49 AM. The seat belt was noted to be very loose around her waist. There were other residents in this room at the time but no activities and the television was off. On 06/27/13 at 8:36 AM Resident #3 was in the dining room with a nurse aide instructor. She had	F 323		

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F 323	Continued From page 56 three alarms in place in her wheelchair. She had a clip on alarm which was not clipped, a seat belt alarm that was not turned on and a pressure pad on the seat which was on. A dycem (non skid) pad was half hanging out of the cushion in her wheelchair. The seat belt was noted to be very loose around her waist. The resident wheeled herself to the hall and sat until while various staff stopped an spoke to her but never checked her alarms. At 9:57 AM, Nurse #1 took her to sit by the medication cart as she administered medications. At this time, Nurse #1 was informed of the alarms not all being on and she attached them. Nurse #1 stated the facility had tried a lap buddy but that agitated her and she threw it on the floor. Per Nurse #1 if the seat belt is too tight around her waist, Resident #3 got very agitated and removed it. Nurse #1 further stated she had seen Resident #3 actually stand and walk with the wheelchair still attached via the belt 3 - 4 times. Nurse #1 also stated Resident #3 had gotten stronger. When asked about the three alarms and how staff were to know what the current alarm usage was, Nurse #1 stated there was a lack of communication when devices were added or changed. Devices just showed up on the resident. She thought the nurse aides would know via the computer system they use for documentation purposes. On 06/27/13 at 3:52 PM Nurse Aide (NA) #3 will walk with her but she shuffles and her knees bother her. NA #3 stated devices have included a tab alarm which she removed, a chair pad alarm and a lap strap. To prevent falls, NA #3 stated they tried to keep a close eye on Resident #3, routinely take her to the bathroom before and after meals, and tried to send her to activities.	F 323		

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F 323	Continued From page 57 On 06/28/13 at 2:50 PM NA #4 stated to prevent Resident #3 from falling, she gave her things to do with her hands, tell her the lap belt looked beautiful, and take her with the NA to do charting. NA #4 stated she was unaware of any ambulation program and stated Resident #3 could not walk and she never tried to ambulate with her. On 06/28/13 at 3:42 PM an interview was conducted with the Administrator and Regional Nurse Consultant. The Administrator stated that falls were discussed in morning meetings. That the staff discuss the specifics of the fall, any changes in environment and each department added any options or interventions they think would prevent falls. Anything that was discussed would be left to the department head to follow through and the department heads would add interventions to the care plan. Per the administrator, the planned interventions on the post fall assessments were in progress and trials. She stated redirection was an ongoing interventions, ambulation assistance was just to assist as necessary, restorative toileting was not necessarily a planned program. The Administrator could not be specific as to what diversional activities would refer to and stated the activity director would know. The activity director was not working this date (last day of survey) and did not return calls. There was no evidence that a restorative ambulation program was initiated per the therapy discharge summary. There was no evidence of a toileting program initiated. The activity care plan was not changed and included no specific activities designed and implemented for Resident	F 323		

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F 323	Continued From page 58 #3. 2. Resident #6 was admitted to the facility on 02/13/13, then was hospitalized on 02/17/13 and readmitted to the facility on 03/11/13. Her diagnoses included delirium, dementia, depression, atrial fibrillation, coronary artery disease, and chronic obstructive pulmonary disease. A care plan was developed 03/11/13 which addressed Resident #6 being at risk for falls due to removing her bed alarm and trying to get out of bed without assistance. The goal was for the resident to have no fall related injuries. Interventions included educating resident to tell health care professionals if feeling dizzy, off balance, weak, etc, monitoring for adverse reactions to medications, educating the resident to rise slowly to prevent a sudden drop in blood pressure, promote adequate hydration, keep environment free of obstacles, encourage involvement in activities, vital signs as ordered and as needed, keep wheels on bed locked, wear well fitting shoes and or nonskid socks when ambulating, assistive devices ad needed, keep call bell in place, keep most used items near resident, encourage frequent rest periods, and ask/encourage/assist resident to toilet. Review of the Falls tracking log revealed Resident #6 fell on 03/14/13. The administrator could not locate the incident report. The nursing notes did not have any incident noted, however there was an entry dated 03/15/13 at 3:02 AM indication this as a late entry that the resident had no verbal complaints of injuries related to the fall on the 7-3 shift.	F 323		

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F 323	Continued From page 59 The admission Minimum data Set (MDS) dated 03/18/13 coded her as having severely impaired cognitive skills, having verbal and physical behaviors and rejecting care and requiring extensive assistance with bed mobility, transfers and walking only once or twice with assistance needed. It was also coded that she had fallen once since admission. The fall Care Area Assessment (CAA) dated 03/22/13 stated Resident #6 was at risk for fall related injuries duet to her decreased strength and balance. She required extensive assistance for transfers and used psychotropic medications and had a history of falls. The plan was to proceed with a care plan. The care plan relating to falls was updated on 03/22/13 with the addition of a removable seat belt at all times while the resident was in the wheelchair. The resident was able to remove it. Review of incident reports revealed: *05/09/13 at 12:00 PM Resident #6 was in her room, unhooked her seat belt, stood, fell and hit her head on the door. The alarm on the seat belt did not sound. The post fall assessment revealed a section that listed applicable interventions initiated in response to the fall and added to the care plan. Post fall interventions included redirect and provide diversional activity. There was nothing documented related to the alarm which did not sound. *05/09/13 at 8:45 PM Resident #6 was observed on the floor in her room sitting on the floor mat with no alarms sounding. The alarm had been on	F 323		

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F 323	Continued From page 60 but the cord was so long it didn't disconnect and sound. Post fall interventions included redirect and provide diversional activity. There was no indication if the alarm was changed out or if the cord was shortened. Review of the activity participation record revealed there were no documented activities for Resident #6 on 05/09/13 through 05/11/13 and no change of activity interventions. *05/14/13 at 3:30 AM a nurse aide observed the resident sliding off the edge of the bed but could not reach the resident in time to prevent her from hitting the floor. The incident report noted the resident had removed the alarm. The corresponding nursing note dated 05/14/13 at 4:41 AM stated the resident had removed the alarm which she had a recurrent history of doing and she was not wearing shoes or socks. The interventions listed on the post fall assessment included redirect and provide diversional activities. *05/19/13 at 6:20 AM staff heard Resident #6 calling out and found her in the bathroom on her knees facing the toilet. The mobility alarm was not clipped to her clothing and she had bare feet. The corresponding nursing note dated 05/19/13 at 7:44 PM stated the mobility alarm was lying on the bed where she apparently unfastened it. The listed post fall interventions included to redirect and provide diversional activities. *06/06/13 at 7:45 AM Resident #6 was found in the sunroom lying on her back and complaining about her head and right elbow. A bruise was forming on her elbow and she was sent tot he emergency room for treatment. The incident	F 323		

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F 323	Continued From page 61 report mentioned the seat belt alarm was repaired. The post fall assessment interventions was to redirect and provide diversional activities. The fall care plan was updated on 06/19/13 to discontinue the resident education to rise slowly, to discontinue vital signs as ordered and prn, to discontinue the assistive devices as needed all noting the reason of the discontinuation due to "resolved." In addition the intervention of the seat belt alarm at all times was discontinued on 06/19/13 noting the reason was it was entered in error and a chair alarm was to be used when resident was in the wheelchair with a start date of 06/25/13. On 06/26/13 at 9:51 AM Resident #6's bed was observed with a tab/clip type alarm on the right turn rail. On 06/26/13 at 9:54 AM, Resident #6 was observed in the sunroom with a very loose alarmed seat belt in place, Resident #6 released the seat belt multiple times sounding the alarm. Staff responded each time. The sunroom was located in the upper end of the hallway and contained a large television, table for dining and large windows between the hall and the sunroom. Interview with Nurse Aide (NA) #3 revealed Resident #6 often removed her alarmed seat belt. NA #3 stated activity department will give her laundry to fold and staff try to hide the belt. According to NA #3 the resident had never been ambulatory but can stand and pivot. NA #3 stated Resident #6 will go to some music groups and staff try to keep an eye on her the best they can.	F 323		

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F 323	Continued From page 62 Interview with NA #5 revealed interventions used to prevent Resident #6 from falling included her alarmed seat belt and keeping an eye on her. NA #% further stated the resident liked to talk. Interview with NA #4 on 06/28/13 at 2:54 PM revealed she gave Resident #6 laundry to fold as she liked to do things with her hands in order to prevent falls. NA #4 stated Resident #6 was hard to redirect. On 06/28/13 at 3:42 PM an interview was conducted with the Administrator and Regional Nurse Consultant. The Administrator stated that falls were discussed in morning meetings. That the staff discuss the specifics of the fall, any changes in environment and each department added any options or interventions they think would prevent falls. Any thing that was discussed would be left to the department head to follow through and add to the care plan. Per the administrator, the planned interventions on the post fall assessments were in progress and trials. She stated redirection was an ongoing interventions. She further stated there was distinct difference regarding care planned interventions of alarms. She stated as long as there was an alarm on that was enough. Any intervention that any department head wanted to implement would be up to the department head to place on the care plan. The Administrator could not be specific as to what diversional activities would refer to and one would have to talk to the activity director to know. The activity director was not working this date (last day of survey) and did not return calls.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		7/26/13

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F 353	Continued From page 63 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide enough staff to provide showers for 3 of 3 residents, supervision of residents to prevent accidents for 3 of 3 residents with accidents and treatment of pressure sores for 1 of 3 residents reviewed for pressure sores (Resident # 3, 5, 6 and 17). The findings included: 1. Resident #5 was admitted to the facility on 05/01/13 with diagnoses which included peri-rectal cellulitis, wounds to buttocks, morbid	F 353	F353 **How the corrective action will be accomplished for the resident(s) affected.** Resident #5 was assessed, treatment provided as ordered and documented. Resident #3 was assessed by therapist for appropriate positioning, devices and appropriate transfers. Resident #6 devices were audited for appropriateness and functionality. Resident #3, #6, and #17 were showered on 6/27/13 **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Staffing for each unit is scheduled to meet the needs of residents on each shift. Any resident needs will be addressed immediately during leadership rounds to ensure staff is providing the necessary care to the residents. Observation by the leadership team will be done five x a week x 2 weeks, weekly x 2 monthly x 2, then quarterly x 3. Staffing deviations noted will be addressed at that time. Nursing Administration have been re-educated on staffing for the	7/26/13

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F 353	Continued From page 64 obesity, diabetes mellitus, chronic lymphedema and anemia. An admission Minimum Data Set (MDS) was completed on 05/08/13 and assessed Resident #5 as cognitively intact for daily decision making. The MDS indicated the resident required extensive assistance of 2 staff with bed mobility, toilet use, personal hygiene and dressing and was totally dependent on staff for bathing. The resident was non-ambulatory during the observation period. The MDS also indicated Resident #5 was frequently incontinent of urine and always incontinent of bowel. The resident was assessed as having moisture associated skin damage and 9 Stage 2 pressure ulcers. The MDS indicated the following interventions were in place: a pressure reducing device for chair, nutrition or hydration intervention, pressure ulcer care, and applications of ointments/medication. The Care Area Assessment (CAA) Summary addressing pressure ulcers indicated Resident #5 was admitted with multiple Stage 2 ulcers on the buttocks and hips and was at risk for developing additional ulcers due to limited mobility and incontinence of bowel and bladder. The decision was made to proceed to care plan. A care plan dated 05/03/13 addressed skin breakdown and multiple Stage 2 pressure ulcers which were present on admission. Interventions included: treatment as ordered by physician, keep skin clean & dry, assist with turning and positioning every 2 hours, use wedge to help keep on side, float heels when in bed and skin assessment weekly.	F 353	facility and the protocol to follow for call-outs by the Administrator. The facility will continue to recruit for positions **Measures in place to ensure practices will not recur.** IDON/ Unit Manager will calculate Master staffing schedules 4 weeks in advance. Daily staffing sheets will be done 2 weeks in advance to ensure sufficient staffing is met. The IDON/Unit Manager will review staffing sheet each day. The Nurse Administrative Staff will assume any positions on the Nursing Unit that are below facility needs. The Administrator will audit Staffing Sheets daily Monday-Friday for 2 weeks; weekly for 2 weeks; monthly for 2 months then quarterly x three for continued compliance or revision to the plan as needed. **How the facility plans to monitor and ensure correction is achieved and sustained.** The Administrator will report results of audits to the QA Committee monthly for three months, then quarterly x three for tracking and trending.	

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F 353	Continued From page 65 The care plan was revised on 06/13/13 to address a Stage 3 sacral pressure ulcer. The care plan indicated barrier cream was to be applied to thighs/buttocks daily and to be sure to keep it away from the transparent film dressing. The sacral wound was to be irrigated with saline, packed with silver alginate, covered with foam and secured with a transparent film dressing daily. Additional interventions included a Group 2 alternating pressure air mattress for pressure reduction and wound consult as indicated. The area on the right posterior thigh was described as a Stage 2 diabetic ulcer. A review of the skin and wound assessment records for Resident #5 revealed a document titled Ulcer and Wound Record which was completed on 05/01/13 and noted that resident had multiple (15 - 20) stage II ulcers on right and left buttocks and left upper lateral thigh which varied in size from 10 centimeters (cm) to 30 cm. No specific measurements were listed for each open area except the left thigh which was listed as 11.4 cm long X 2.0 cm wide and described as intact blisters with no drainage; the peri-wound area was described as intact. There were not any measurements between 05/01/13 and 05/18/13. Additional measurements of the left thigh were done on 05/18/13, 06/05/13, 06/11/13 and 06/18/13. An ulcer and wound record dated 05/08/13 listed the right inner buttocks: 6.2 cm long X 4.0 cm wide X 0.2 cm deep with serosanguinous drainage and wound bed had slough and granulation tissue; the peri-wound was red/inflamed. There were not any measurements between 05/08/13 and 05/23/13. Additional	F 353		

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F 353	Continued From page 66 measurements of the right inner buttocks were done on 05/23/13 and 06/05/13. An ulcer and wound record dated 05/8/13 listed the left inner cheek (buttock): 7.2 cm long X 5.3 cm wide with eschar and the peri-wound was red/inflamed. There were not any measurements between 05/08/13 and 05/23/13. Additional measurements of the left inner buttock were done on 05/23/13, 06/05/13, 06/11/13 and 06/18/13. A review of the May and June 2013 Treatment Administration (TAR) records for Resident #5 revealed the following documentation: An air mattress with a pump was documented as being on Resident #5's bed beginning 05/28/13. Extra protective cream to buttocks covered with viscopaste strips twice daily was documented as started 05/01/13 and discontinued 06/06/13 - there were 35 instances when it was not documented as done. Xeroform dressing covered with viscopaste strips twice daily was documented as started 05/28/13 and discontinued 06/06/13 but was not documented as done on 05/28/13, on 05/29/13 at 5:00 PM, on 05/30/13 at 9:00 AM; it was not documented as done at all from 05/31/13 through 06/03/13, on 06/04/13 at 9:00 AM; and it was not documented as done at all on 06/05/13 or 06/06/13. Santyl ointment to coccyx daily was documented beginning 06/06/13 through 06/12/13 but was only documented as done on 06/09/13 and 06/12/13.	F 353		

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F 353	Continued From page 67 Dakin's 0.25% solution apply twice daily topical for wound was documented as started 06/12/13 and discontinued 06/25/13 but was not documented as done at all on 06/13/13 through 06/15/13, on 06/18/13 at 9:00 PM, on 06/21/13 at 9:00 AM, on 06/22/13 at 9:00 AM or on 06/23/13 at 9:00 PM. Irrigate sacral wound with saline, pack with silver alginate, cover with foam, secure with transparent dressing daily was documented beginning 06/26/13. A group 3 air fluidized mattress for stage 3 pressure ulcer was documented as started on 06/18/13. An interview on 06/26/13 at 3:35 PM with Nurse #1 revealed the nurses weren't doing the treatments as ordered for Resident #5 because there weren't enough NAs to assist with repositioning the resident so the nurse could do the treatment. Nurse #1 stated a specialty mattress was not placed on Resident #5's bed until 05/24/13. Nurse #1 also stated wound measurements weren't being done every week as they should be. An interview on 06/26/13 at 5:02 PM with Nurse #2 revealed the nurses are responsible for doing all the treatments as well as administering medications. Nurse #2 stated just administering the medications often takes all shift so the nurses aren't consistently getting the treatments done because there isn't enough time. An interview on 06/27/13 at 5:30 PM with the	F 353		

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F 353	Continued From page 68 physician about Resident #5's wounds revealed he was asked to see the resident on 05/23/13 to assess skin breakdown on the buttocks. He stated he saw the resident again on 05/25/13 and asked staff to get an air mattress for the resident. He stated he examined Resident #5's wound on the buttocks on 05/28/13 and thought it was getting better. He stated he looked at the wound on Resident #5's buttocks again on 06/06/13 and the area was much worse; at that point the wound had eschar and he referred the resident to the Wound Clinic as soon as possible for debridement. The physician was asked about his expectation for measuring and monitoring of wounds and he stated the nurses should be measuring and monitoring the areas. An interview on 06/28/13 at 11:15 AM with the Regional Nurse Consultant about the expectation for assessment of open wounds revealed that all open wounds should be assessed weekly and the assessment should include measurements of the wound. When asked if there were any additional measurements of Resident # 5's wounds, he stated the facility was unable to locate any wound measurements done between 05/08/13 and 05/23/13. He stated his expectation was for all wounds to be assessed and measured every week whether they were due to pressure or not. 2. Resident #3 was admitted to the facility on 03/13/13 with diagnoses including Alzheimer's type dementia with behavioral disturbances, major depressive disorder, generalized anxiety disorder, coronary artery disease,	F 353		

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F 353	Continued From page 69 hypothyroidism, and hyperlipidemia. The admission Minimum Data Set (MDS) dated 03/20/13 coded her with severely impaired cognitive skills, and requiring supervision with bed mobility, transfers, and walking. She was coded as being steady with balance at all times. She had wandering behaviors 4 to 6 days, but less than daily. She was coded as having no falls prior to admission or since admission. The Care Area Assessment (CAA) dated 03/26/13 stated Resident #3 was at risk for fall related injuries due to her use of psychotropic medication and severe cognitive impairment resulting in poor safety awareness. The CAA stated a care plan would be developed to prevent fall related injuries. A care plan developed 03/20/13 which addressed the problem of Resident #3 being at risk for falls had the goal of no fall related injury through next review. Interventions included keeping most used items near resident, encourage frequent rest periods, ask/encourage/assist resident to toilet, keep call bell in place, educate resident to rise slowly to prevent a sudden dropping blood pressure, promote adequate hydration, monitor for adverse reaction to medications, educate resident to tell health care professionals if feeling dizzy, off balance, weak, etc., keep environment free of potential obstacles, wear well fitting shoes or nonskid socks, assistive devices as needed, keep wheels on bed locked, encourage involvement in activities, vital signs as ordered and as needed. Physical therapy was started on 04/04/13 due to her exhibiting a shuffling gait with ambulation.	F 353		

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F 353	Continued From page 70 Review of the incident reports revealed the following falls: *04/17/13 at 7:50 PM the nurse was passing medication, heard a loud bang and found resident sitting on the floor with her head resting on the door. It was noted Resident #3 was resting in bed earlier. Post fall interventions listed included provide ambulation assistance, bed alarm for safety. The nursing notes dated 04/17/13 at 10:04 PM noted a pressure sensitive alarm was applied for safety. *04/19/13 at 6:15 AM she was in the sunroom and was observed sitting on the floor in front of her wheelchair. A self release seat belt was placed on Resident #3 at that time. Post fall interventions included a pharmacy consult, provide ambulation assistance, a restorative toileting program, and verbal cues. There was no evidence in the medical record that an ambulation program or toileting program was initiated. A significant change MDS dated 04/25/13 coded Resident #3 with severely impaired cognitive skills, having no behaviors, and requiring extensive assistance with bed mobility, transfers, and limited assistance with ambulation. It was noted she was not steady but able to stabilize herself without help when walking and turning around but needed staff assistance to stabilize when moving from seated to standing position, moving on and off toilet and surface to surface transfers. She had 2 falls and had declined physically resulting in a shuffling gait and had been transitioned to a wheelchair for safety as she was no longer able to use her walker.	F 353		

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F 353	Continued From page 71 Physical therapy discharged Resident #3 on 05/01/13 due to severe cognition and being unable to follow through with teaching. It was determined she was high risk for falls and was safer in a wheelchair. The discharge note stated restorative nursing had been educated in ambulation. There was no evidence in the medical record of a restorative ambulation program for Resident #3. Resident #3 continued to fall as evidenced by the following incident reports: *05/08/13 at 3:00 PM Resident #3 was placed in bed after lunch and then found on the floor in her room sitting on her buttocks. Interventions per the post fall assessment to be added to the care plan included pharmacy consult, ambulation assistance, restorative toileting and verbal cues. There was no evidence of a restorative toileting program. *05/09/13 at 6:45 PM Resident #3 was observed on the floor in her room on the side of the bed, kneeling on the floor mat with the alarm sounding. Interventions post fall to be added to the care plan included pharmacy consult, provide ambulation assistance, restorative toileting, verbal cues. There was no evidence of a restorative toileting program. *05/11/13 at 10:30 AM resident was found on the floor in front of her wheelchair in the sunroom with her alarm going off. Resident #3 was noted with bruising and a skin tear to her right elbow. The post fall interventions included pain management and assessment, activities consult	F 353		

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F 353	Continued From page 72 for increased stimulation, redirect and provide diversional activity, relocate to high visibility area, family involvement and educate resident regarding calling for assistance. *05/14/13 at 10:00 AM Resident #3 observed sitting on the floor on her buttocks in the sunroom in front of the wheelchair. Post fall interventions included pain management, activities consult for increased stimulation, redirect and provide diversional activities, relocate to high visibility area, family involvement and educate resident regarding using call bell for assistance. *05/15/13 at 3:45 PM Resident #3 was witnessed in the hall removing her self release lap belt and standing up. Before the nurse aide could reach her, Resident #3 staggered backwards and sat on the floor. Some redness was noted to buttocks and left elbow. Post fall assessment included activities consult for increased stimulation and redirect and provide diversional activities. *06/25/13 at 6:05 PM Resident was in the hallway and self released her seat belt and attempted to stand and slid to the floor, sitting on her buttocks. The post fall assessment included interventions of provide ambulation assistance, redirections and provide diversional activities, and to relocate the resident to a high visible area. An alert oriented resident witnessed this fall. The sunroom was located in the upper end of the hallway and contained a large television, table for dining and large windows between the hall and the sunroom. Resident #3 was observed in a wheelchair with a self release alarmed belt in place on 06/26/13 at 9:59 AM, 10:23 AM and	F 353		

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F 353	Continued From page 73 10:49 AM. The seat belt was noted to be very loose around her waist. There were other residents in this room at the time but no activities and the television was off. On 06/26/13 at 2:08 PM, Nurse #1 stated there were not enough staff to help Resident #3 ambulate which was all the resident wanted to do. Restorative nursing was supposed to be done by floor nurse aides but there was not enough aides to do restorative ambulation. On 06/27/13 at 8:57 AM, Nurse Aide (NA) #1 stated at least twice a month, mostly on weekends, there was only one nurse aide for the entire hall of 32 residents. On 06/27/13 at 2:53 PM NA #3 stated there have been lots of turn over in the last month or so. Lately she had been working on this all by herself for the last couple of weekends. She stated she does the best she can to care for the residents. To prevent falls, NA #3 stated they tried to keep a close eye on Resident #3, routinely take her to the bathroom before and after meals, and tried to send her to activities. On 06/28/13 at 10:10 AM NA #4 stated there are often just 1 to 2 nurse aide on this wing and often don't have time to do everything including watching for this resident who is high risk for falls. On 06/28/13 at 3:42 PM an interview was conducted with the Administrator and Regional Nurse Consultant. The Administrator stated that falls were discussed in morning meetings. That the staff discuss the specifics of the fall, any changes in environment and each department	F 353		

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(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 353	Continued From page 74 added any options or interventions they think would prevent falls. Anything that was discussed would be left to the department head to follow through and the department heads would add to the care plan. Per the administrator, the planned interventions on the post fall assessments were in progress and trials. She stated redirection was an ongoing interventions, ambulation assistance was just to assist as necessary, restorative toileting was not necessarily a planned program. The Administrator could not be specific as to what diversional activities would refer to and stated the activity director would know. The activity director was not working this date (last day of survey) and did not return calls. There was no evidence that a restorative ambulation program was initiated per the therapy discharge summary. There was no evidence of a toileting program initiated. The activity care plan was not changed and included no specific activities designed and implemented for Resident #3. 3. Resident #6 was admitted to the facility on 02/13/13, then was hospitalized on 02/17/13 and readmitted to the facility on 03/11/13. Her diagnoses included delirium, dementia, depression, atrial fibrillation, coronary artery disease, and chronic obstructive pulmonary disease. A care plan was developed 03/11/13 which addressed Resident #6 being at risk for falls due to removing her bed alarm and trying to get out of bed without assistance. The goal was for the resident to have no fall related injuries. Interventions included educating resident to tell	F 353		

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	345418	A. BUILDING _____ B. WING _____	C 06/28/2013

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F 353	Continued From page 75 health care professionals if feeling dizzy, off balance, weak, etc, monitoring for adverse reactions to medications, educating the resident to rise slowly to prevent a sudden drop in blood pressure, promote adequate hydration, keep environment free of obstacles, encourage involvement in activities, vital signs as ordered and as needed, keep wheels on bed locked, wear well fitting shoes and or nonskid socks when ambulating, assistive devices ad needed, keep call bell in place, keep most used items near resident, encourage frequent rest periods, and ask/encourage/assist resident to toilet. Review of the Falls tracking log revealed Resident #6 fell on 03/14/13. The administrator could not locate the incident report. The nursing notes did not have any incident noted, however there was an entry dated 03/15/13 at 3:02 AM indication this as a late entry that the resident had no verbal complaints of injuries related to the fall on the 7-3 shift. The admission Minimum data Set (MDS) dated 03/18/13 coded her as having severely impaired cognitive skills, having verbal and physical behaviors and rejecting care and requiring extensive assistance with bed mobility, transfers and walking only once or twice with assistance needed. It was also coded that she had fallen once since admission. The care plan relating to falls was updated on 03/22/13 with the addition of a removable seat belt at all times while the resident was in the wheelchair. The resident was able to remove it. Review of incident reports revealed:	F 353		

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F 353	Continued From page 76 *05/09/13 at 12:00 PM Resident #6 was in her room, unhooked her seat belt, stood, fell and hit her head on the door. The alarm on the seat belt did not sound. Post fall interventions included redirect and provide diversional activity. There was nothing documented related to the alarm which did not sound. *05/09/13 at 8:45 PM Resident #6 was observed on the floor in her room sitting on the floor mat with no alarms sounding. The alarm had been on but the cord was so long it didn't disconnect and sound. Post fall interventions included redirect and provide diversional activity. *05/14/13 at 3:30 AM a nurse aide observed the resident sliding off the edge of the bed but could not reach the resident in time to prevent her from hitting the floor. The incident report noted the resident had removed the alarm. The interventions listed on the post fall assessment included redirect and provide diversional activities. *05/19/13 at 6:20 AM staff heard Resident #6 calling out and found her in the bathroom on her knees facing the toilet. The mobility alarm was not clipped to her clothing and she had bare feet. The listed post fall interventions included to redirect and provide diversional activities. *06/06/13 at 7:45 AM Resident #6 was found in the sunroom lying on her back and complaining about her head and right elbow. A bruise was forming on her elbow and she was sent tot he emergency room for treatment. The incident report mentioned the seat belt alarm was	F 353		

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F 353	Continued From page 77 repaired. The post fall assessment interventions was to redirect and provide diversional activities. The fall care plan was updated on 06/19/13 to discontinue the resident education to rise slowly, to discontinue vital signs as ordered and prn, to discontinue the assistive devices as needed all noting the reason of the discontinuation due to "resolved." In addition the intervention of the seat belt alarm at all times was discontinued on 06/19/13 noting the reason was it was entered in error and a chair alarm was to be used when resident was in the wheelchair with a start date of 06/25/13. On 06/26/13 at 9:54 AM, Resident #6 was observed in the sunroom with a very loose alarmed seat belt in place, Resident #6 released the seat belt multiple times sounding the alarm. Staff responded each time. The sunroom was located in the upper end of the hallway and contained a large television, table for dining and large windows between the hall and the sunroom. Interview with Nurse Aide (NA) #3 on 06/27/13 at 2:53 PM revealed Resident #6 often removed her alarmed seat belt. She stated that there had been turn over the last couple of months and she had worked by herself on this unit. She stated she tried to do the best she could. Interview with NA #5 on 06/27/13 at 8:57 AM revealed interventions used to prevent Resident #6 from falling included her alarmed seat belt and keeping an eye on her. NA #5 further stated the resident liked to talk. On 06/28/13 at 10:10 AM NA #4 stated there are	F 353		

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F 353	Continued From page 78 often just 1 to 2 nurse aide on this wing and often don't have time to do everything including watching for this resident who is high risk for falls. Interview with NA #4 on 06/28/13 at 2:54 PM revealed she gave Resident #6 laundry to fold as she liked to do things with her hands in order to prevent falls. NA #4 stated Resident #6 was hard to redirect and short staffing resulted in a lack of supervision for this resident. . On 06/28/13 at 3:42 PM an interview was conducted with the Administrator and Regional Nurse Consultant. The Administrator stated that falls were discussed in morning meetings. That the staff discuss the specifics of the fall, any changes in environment and each department added any options or interventions they think would prevent falls. Any thing that was discussed would be left to the department head to follow through and added to the care plan. Per the administrator, the planned interventions on the post fall assessments were in progress and trials. She stated redirection was an ongoing interventions. She further stated there was distinct difference regarding care planned interventions of alarms. She stated as long as there was an alarm on that was enough. Any intervention that any department head wanted to implement would be up to the department head to place on the care plan. The Administrator could not be specific as to what diversional activities would refer to and one would have to talk to the activity director to know. The activity director was not working this date (last day of survey) and did not return calls. 4. Resident #6 was admitted to the facility on	F 353		

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F 353	Continued From page 79 02/13/13, then was hospitalized on 02/17/13 and readmitted to the facility on 03/11/13. Her diagnoses included delirium, dementia, depression, atrial fibrillation, coronary artery disease, and chronic obstructive pulmonary disease. The admission Minimum data Set (MDS) dated 03/18/13 coded her as having severely impaired cognitive skills, having verbal and physical behaviors and rejecting care and requiring extensive assistance with bed mobility, transfers and bathing. A care plan was developed on 03/22/13 to address the inability of Resident #6 to complete activities of daily living (ADL) tasks. Interventions included to assist the resident to shower twice a week. Review of the ADL Data Report, completed by nursing assistants, revealed Resident #3 did not receive a shower from 05/31/13 through 06/05/13 (6 days) and from 06/21/13 through 06/26/13 (6 days). On 06/26/13 at 2:08 PM, Nurse #1 stated showers were not getting completed due to short staffing. She further stated when it has been reported to her that staff can't complete showers, she has told the nurse aides to do the best they can and Nurse #1 tried to prioritize what care and what resident would be most important not to skip. Nurse Aide (NA) # 3 stated on 06/27/13 at 2:53 PM that staffing has been short for the last month or so. She stated if showers cannot be	F 353		

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F 353	Continued From page 80 completed then they try to give good bed baths and make up the shower on the next day or wait until the next shower day. NA #9 stated on 06/27/13 at 5:31 PM stated that showers are difficult to complete as scheduled due to staffing. She stated that staff report this to the nurses who stated that a bed bath was acceptable. On 06/28/13 at 10:10 AM, NA #4 stated due to short staffing, showers were not always completed twice a week. Staff try to make a missed shower up the next day as able. Interview with the administrator on 06/28/13 at 4:55 PM revealed if a nurse aide could not do a shower for some reason, the nurse aide should ask the resident if it would be alright to make it up the next day or pass it off to the next shift to complete. She further stated she was unaware showers were not being given as scheduled. 5. Resident #3 was admitted to the facility on 03/13/13 with diagnoses including Alzheimer's type dementia with behavioral disturbances, major depressive disorder, generalized anxiety disorder, coronary artery disease, hypothyroidism, and hyperlipidemia. The admission Minimum Data Set (MDS) dated 03/20/13 coded her with severely impaired cognitive skills, and requiring supervision with bed mobility, transfers, and walking and requiring physical help with bathing. A care plan was developed on 03/26/13 which addressed her inability to complete activities of	F 353		

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F 353	Continued From page 81 daily living (ADL) tasks . Interventions included to assist the resident to shower twice a week. Review of the ADL Data Report, completed by nursing assistants, revealed Resident #3 did not receive a shower on 04/02/13 through 04/07/13 (6 days) and again from 04/16/13 through 04/21/13 (6 days). On 06/26/13 at 2:08 PM, Nurse #1 stated showers were not getting completed due to short staffing. She further stated when it has been reported to her that staff can't complete showers, she has told the nurse aides to do the best they can and Nurse #1 tries to prioritize what care and what resident would be most important not to skip. Nurse Aide (NA) # 3 stated on 06/27/13 at 2:53 PM that staffing has been short for the last month or so. She stated if showers cannot be completed then they try to give good bed baths and make up the shower on the next day or wait until the next shower day. NA #9 stated on 06/27/13 at 5:31 PM stated that showers are difficult to complete as scheduled due to staffing. She stated that staff report this to the nurses who stated that a bed bath was acceptable. On 06/28/13 at 10:10 AM, NA #4 stated due to short staffing, showers were not always completed twice a week. Staff try to make a missed shower up the next day as able. Interview with the administrator on 06/28/13 at 4:55 PM revealed if a nurse aide could not do a	F 353		

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F 353	Continued From page 82 shower for some reason, the nurse aide should ask he resident if it would be alright to make it up the next day or pass it off to the next shift to complete. She further stated she was unaware showers were not being given as scheduled. 6. Resident #17 was admitted to the facility on 03/19/13 with diagnoses which included multiple sclerosis, osteoporosis, muscle weakness and depression. The most recent quarterly Minimum Data dated 06/28/13 indicated Resident #17 was cognitively intact and required extensive assistance with hygiene and was totally dependent on staff for bathing. A review of care plans dated 04/01/13 indicated a problem statement that Resident #17 was unable to complete tasks related to personal care. The goals indicated Resident #17 will be well groomed and dressed appropriately and activities of daily living tasks will be addressed through next review date of 04/03/13. The approaches on the care plan were listed in part to provide assistance with personal hygiene and grooming needs as needed and assist resident to shower twice a week. A review of a shower schedule indicated Resident #17 was scheduled for a shower on Tuesday and Friday of each week on second shift between 3:00 PM and 11:00 PM. During an observation on 06/27/13 at 9:51 AM Resident #17 was lying in bed in her room. She was dressed in a gown, her hair was uncombed and oily there was a sour odor.	F 353		

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F 353	Continued From page 83 During an interview on 06/27/13 at 9:52 AM Resident #17 stated she hasn't had a shower or had her hair washed since last Saturday. She explained she missed her shower last Friday evening. She further stated she was told she would get a shower on the 3:00 PM to 11:00 PM shift on Tuesday night but she didn't get it. Resident #17 explained she was the Vice-Chairman of the Resident Council and they had discussed resident concerns about not getting showers at the council meetings and felt there was not enough staff to provide showers to residents as scheduled. During an interview on 06/27/13 at 5:40 PM with NA #5 he stated sometimes staffing was an issue and they can't get all the showers done on the second shift shower schedule. He further stated that once a shower got behind it was nearly impossible to catch up. He explained Resident #17's shower was not done on Tuesday night because they were overwhelmed to get everything done. During an interview on 06/27/13 at 6:03 PM with NA #11 explained she gave Resident #17 her shower last Saturday because she didn't get one on Friday. She stated she did try to give bed baths if a shower was missed but sometimes they couldn't get them all done. During an interview on 06/28/13 at 3:56 PM the Administrator stated it was her expectation that resident's should get a shower when they wanted a shower. She further stated if a shower was missed the NA's should talk with the resident and find out when they wanted their shower done and accommodate the resident's needs. She further	F 353		

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F 353	Continued From page 84 stated the NA's should also communicate with the nurse when a resident's shower was missed.	F 353		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to maintain an emergency supply of narcotic medications available for 6 of 6 medication carts in the facility which resulted in medications which were dispensed for one resident being administered to another resident. The findings included: 1. A review of the Controlled Medication	F 425	F425 **How the corrective action will be accomplished for the resident(s) affected.** On Jun 26, 2013, Interim DON went to the Pyxis and did an inventory of the Narcotics. He received instruction on ordering narcotics from the pharmacy from and completion of the DEA Form 222 from the Nurse Consultant. Stock was ordered to replenish the Pyxis. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Staff Nurses were re-educated on the Best Practice to not borrow medications and the protocol to notify the physician to obtain a new or alternate prescription by the prior Administrator on 7/1/13 and the Omnicare Pharmacy Technician on 7/11/13. The Pharmacy will provide education again next	7/26/13

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F 425	Continued From page 85 Utilization Record for the hydrocodone/acetaminophen 10/325 milligrams (mg), which was dispensed for Resident #19, revealed a total of 10 doses were administered to Resident # 27 between 06/15/13 and 06/18/13. a. On 06/15/13 at 2:00 PM Nurse # 7 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. b. On 06/15/13 at 6:00 PM Nurse # 7 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. c. On 06/16/13 at 2:00 PM Nurse # 7 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. d. On 06/16/13 at 7:00 PM Nurse # 8 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. e. On 06/17/13 at 12:00 AM Nurse # 9 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. f. On 06/17/13 at 6:00 AM Nurse # 9 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. g. On 06/17/13 at 1:00 PM Nurse # 7 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. h. On 06/17/13 at 6:50 PM Nurse # 8 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. i. On 06/18/13 at 6:00 PM Nurse # 3 administered	F 425	month. The residents Narcotic Administration sheets will be reviewed weekly by the Unit Manager to ensure an ample supply of medications. **Measures in place to ensure practices will not occur.** IDON to inventory Pyxis narcotics on Monday mornings and Thursday evening to routinely replenish the Pyxis. If nurses go to the Pyxis and find that the medication needed is not present then they are to immediately notify the physician on call to either obtain a prescription for a different narcotic that is available for a one time use and/or a prescription to obtain medication from a back-up pharmacy. **How the facility plans to monitor and ensure correction is achieved and sustained.** IDON will copy the inventory sheet and submit it to the Administrator weekly. Nurses will complete a Communication Form for the IDON when	

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F 425	Continued From page 86 to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. j. On 06/18/13 at 9:00 PM Nurse # 3 administered to Resident # 27 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident # 18. A review of the Controlled Medication Utilization Record for the hydrocodone/acetaminophen 10/325 mg, which was dispensed for Resident # 27 on 06/18/13, did not reveal any documentation that indicated 10 tablets were replaced to Resident # 18. 2. A review of the Controlled Medication Utilization record for the oxycodone 5 mg, which was dispensed for Resident # 18, revealed Nurse # 6 administered one tablet to Resident # 26 on 05/14/13 at 5:00 PM. The facility was unable to locate the Controlled Medication Utilization record for the oxycodone 5mg, which was dispensed for Resident # 26. 3. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg, which was dispensed for Resident # 20, revealed Nurse # 3 administered 2 tablets to Resident # 27 on 06/18/13 at 9:00 PM. A review of the Controlled Medication Utilization Record for the lorazepam 1 mg, which was dispensed for Resident # 27, did not reveal any documentation that indicated the medication was replaced to Resident # 20. 4. A review of the Controlled Medication Utilization record for the hydrocodone/acetaminophen 5/500 mg, which was dispensed for Resident # 21, revealed Nurse # 3 administered 2 tablets to Resident # 28 on	F 425	medications are low to expedite refills of the Pyxis. Both the Inventory Sheet and Communication sheets are to be submitted to the Administrator weekly for a period of three months, then quarterly x 3. Results will be addressed with the QA committee monthly for three months, then quarterly x 3 for compliance and revision as needed.	

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ASHEVILLE HEALTH CARE CENTER	1984 HIGHWAY 70 SWANNANOA, NC 28778

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F 425	Continued From page 87 05/23/13 at 4:30 PM. A review of the Controlled Medication Utilization record for the hydrocodone/acetaminophen 5/500 mg, which was dispensed for Resident # 28, did not reveal any documentation that indicated the medication was replaced to Resident # 21. 5. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg, which was dispensed for Resident # 22, revealed Nurse # 3 administered 1 tablet to Resident # 25 on 06/18/13 at 10:00 PM. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg, which was dispensed for Resident # 25 on 06/19/13, did not reveal any documentation that indicated the medication was replaced to Resident # 22. 6. A review of the Controlled Medication Utilization record for the zolpidem 5 mg, which was dispensed for Resident # 23, revealed a total of 2 doses was administered to Resident # 12. a. On 06/10/13 at 10:00 PM Nurse # 10 administered to Resident # 12 one tablet of zolpidem 5 mg which was dispensed for Resident # 23. b. On 06/11/13 at 9:00 PM Nurse # 6 administered to Resident # 12 one tablet of zolpidem 5 mg which was dispensed for Resident # 23. A review of the Controlled Medication Utilization record for the zolpidem 5mg, which was dispensed for Resident # 12 on 06/12/13, did not reveal any documentation that indicated the medication was replaced to Resident # 23. 7. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg, which	F 425		

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F 425	Continued From page 88 was dispensed for Resident # 24, revealed a total of 2 doses was administered to Resident # 29. a. On 05/10/13 at 2:00 PM Nurse # 5 administered to Resident # 29 one tablet of lorazepam 0.5 mg which was dispensed for Resident # 24. b. On 05/13/13 at 8:00 PM Nurse # 5 administered to Resident # 29 one tablet of lorazepam 0.5 mg which was dispensed for Resident # 24. The facility was unable to locate the Controlled Medication Utilization Record for the lorazepam 0.5 mg which was dispensed for Resident # 29. 8. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg, which was dispensed for Resident # 25, revealed a total of 3 doses was administered to Resident # 30. a. On 06/19/13 at 3:30 PM Nurse # 6 administered to Resident # 30 one tablet of lorazepam 0.5 mg which was dispensed for Resident # 25. b. On 06/20/13 at 6:00 PM Nurse # 6 administered to Resident # 30 one tablet of lorazepam 0.5 mg which was dispensed for Resident # 25. c. On 06/20/13 at 10:20 PM Nurse # 6 administered to Resident # 30 one tablet of lorazepam 0.5 mg which was dispensed for Resident # 25. 9. A review of the Controlled Medication Utilization record for the vicodin 500 mg, which was dispensed for Resident # 39, revealed a total of 2 doses were administered to Resident # 34.	F 425		

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F 425	Continued From page 89 a. On 05/28/13 at 10:45 PM Nurse # 3 administered to Resident # 34 one tablet of vicodin 500 mg which was dispensed for Resident # 39. b. On 05/30/13 at 9:00 PM Nurse #6 administered to Resident #34 one tablet of vicodin 500 mg which was dispensed for Resident # 39. A review of the Controlled Medication Utilization record for the vicodin 500 mg which was dispensed for Resident # 39 on 05/30/13, did not reveal any documentation that indicated that 2 tablets were replaced to Resident #39. 10. A review of the Controlled Medication Utilization record for the hydrocodone-acetaminophen 325 mg, which was dispensed for Resident #8, revealed Nurse #3 administered 1 tablet to Resident #41 on 06/02/13 at 8:45 PM. A review of the Controlled Medication Utilization record for the hydrocodone-acetaminophen 325 mg, which was dispensed for Resident #41, did not reveal any documentation that indicated medication was replaced to Resident #8. 11. A review of the Controlled Medication Utilization Record for the hydrocodone/acetaminophen 325 mg, which was dispensed for Resident #36, revealed a total of 2 doses were administered to Resident #35 between 05/06/13 and 05/10/13 and a total of 2 doses were administered to Resident #2 between 05/23/13 and 05/24/13. a. On 05/06/13 at 4:00 PM Nurse #6 administered to Resident #35 one tablet of hydrocodone/acetaminophen 325 mg which was dispensed to Resident #36. b. On 05/10/13 at 6:30 PM Nurse #6 administered	F 425		

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F 425	Continued From page 90 to Resident #35 one tablet of hydrocodone/acetaminophen 325 mg which was dispensed to Resident #36. c. On 05/23/13 at 5:00 PM Nurse #6 administered one tablet of hydrocodone/acetaminophen 325 mg which was dispensed to Resident #2. d. On 05/24/13 at 10:00 AM Nurse #1 administered one tablet of hydrocodone/acetaminophen 325 mg which was dispensed to Resident #2. A review of the Controlled Medication Utilization record for the hydrocodone/acetaminophen 325 mg which was dispensed for Resident #36 on 06/24/13, did not reveal any documentation that indicated that 4 tablets were replaced to Resident #36. 12. A review of the Controlled Medication Utilization record for the oxycodone hydrochloride 5 mg, which was dispensed for Resident #13, revealed Nurse #6 administered 2 tablets to Resident #42 on 06/25/13 at 7:30 PM. The facility was unable to locate the Controlled Medication Utilization Record for the oxycodone hydrochloride 5 mg which was dispensed for Resident #13. 13. A review of the Controlled Medication Utilization record for the hydrocodone/acetaminophen 10/325 mg, which was dispensed for Resident #34, revealed a total of 2 doses was administered to Resident #30. a. On 06/19/13 at 1:00PM Nurse #10 administered to Resident #30 one tablet of hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident #34. b. On 06/19/13 at 5:50 PM Nurse #10 administered to Resident #30 one tablet of	F 425		

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F 425	Continued From page 91 hydrocodone/acetaminophen 10/325 mg which was dispensed for Resident #34. A review of the Controlled Medication Utilization record for the hydrocodone/acetaminophen 10/325 mg, which was dispensed for Resident # 34 on 06/19/13, did not reveal any documentation that indicated the medication was replaced to Resident #34. 14. A review of the Controlled Medication Utilization record for the lorazepam 1 mg, which was dispensed for Resident #33, revealed Nurse #1 administered 1 tablet to Resident #32 on 06/26/13 at 9:00 AM. A review of the Controlled Medication Utilization record for the lorazepam 1mg which was dispensed for Resident #33 on 06/24/13, did not reveal any documentation that indicated the medication was replaced to Resident #33. 15. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg, which was dispensed for Resident #3, revealed a total of 2 doses were administered to Resident #6. a. On 06/23/13 at 5:30 AM Nurse #12 administered to Resident #6 one tablet of lorazepam 0.5 mg which was dispensed for Resident #3. b. On 06/24/13 at 7:00 PM Nurse #12 administered to Resident #6 one tablet of lorazepam 0.5 mg which was dispensed for Resident #3. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg, which was dispensed for Resident #3 on 06/24/13, did not reveal any documentation that indicated that 2 tablets were replaced to Resident #3. 16. A review of the Controlled Medication	F 425		

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F 425	Continued From page 92 Utilization record for clonazepam 0.5 mg, which was dispensed for Resident # 32, revealed Nurse#11 administered 1 tablet to Resident # 40 one tablet of clonazepam 0.5 mg which was dispensed for Resident# 32 on 06/18/13 at 8:00 PM . A review of the Controlled Medication Utilization record for theclonazepam 0.5 mg which was dispensed for Resident # 32 on 06/18/13, did not reveal any documentation that indicated the medication was replaced to Resident #32. 17. A review of the Controlled Medication Utilization record for lorazepam 0.5 mg, which was dispensed for Resident #31, revealed Nurse #7 administered 1 tablet to Resident #43 on 06/19/13 at 2:00 PM. A review of the Controlled Medication Utilization record for the lorazepam 0.5 mg which was dispensed for Resident #31 on 06/19/13, did not reveal any documentation that indicated the medication was replaced to Resident #31. A review of the facility's stock of emergency narcotic medications revealed the supply included hydrocodone/acetaminophen 5/500 mg with a par level of 11, lorazepam 0.5 mg with a par level of 12, oxycodone 5 mg with a par level of 7. The facility did not have hydrocodone/acetaminophen 10/325 mg or zolpidem 5 mg available in the emergency supply of narcotic medications. A review of the documentation of the orders submitted for refills indicated an order form dated 04/15/13 which indicated 7 oxycodone 5 mg were ordered - the form did not indicate how many were in stock at that time. An order form dated 04/24/13 indicated 4 oxycodone 5 mg were	F 425		

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F 425	Continued From page 93 ordered - the form did not indicate how many were in stock at that time. An order form dated 06/13/13 indicated the facility had no lorazepam 0.5 mg in stock and 11 were ordered; the facility had 2 hydrocodone/acetaminophen 5/500 mg in stock and 9 were ordered; the facility had no oxycodone 5 mg in stock and 7 were ordered. An order form dated 06/26/13 indicated the facility had no lorazepam 0.5 mg in stock and 11 were ordered; the facility had 2 hydrocodone/acetaminophen 5/500 mg in stock and 9 were ordered; the facility had no oxycodone 5 mg in stock and 7 were ordered. No additional records for the facility's stock of emergency narcotic medications was available. An interview on 06/25/13 at 4:51 PM with Nurse #3 revealed there have been occasions where she would have to borrow medications. She stated she would send a note to the Pharmacy and the Pharmacy would send an extra pill the next day. Nurse #3 further stated she would make a note on the Controlled Medication Utilization record so there would be a record of it. An interview on 06/26/13 at 11:03 AM with Nurse #4 revealed there were occasions when a resident would run out of medication and she would borrow the medication from another resident. She stated in those instances she would document on the Controlled Medication Utilization record the name of the resident to whom the medication was administered. An interview on 06/26/13 at 11:05 AM with the Medical Director revealed he was not aware of any problem with getting emergency medications as a significant issue. He stated the pharmacist	F 425		

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F 425	Continued From page 94	F 425		

was good to notify him when residents were needing refills of narcotic medications so he could order a refill of the medication.

An interview on 06/26/13 at 2:19 PM with Nurse #1 revealed there was an on-going problem with getting medication refills from the pharmacy. She stated it sometimes took 2 weeks to get medications.

An interview on 06/27/13 at 9:26 AM with the Regional Nurse Consultant revealed he was not aware of any problem with getting medications from the pharmacy. He stated the Director of Nursing was responsible for ordering narcotic medications for the facility's emergency supply. He stated he was not aware there was a problem with emergency narcotic medications not being available. He stated he recalled one incident when a nurse asked him about borrowing a pain medication for a resident from another resident and he told the nurse she could borrow the medication but she needed to replace it when the resident's medication arrived from the pharmacy.

An interview on 06/27/13 at 11:05 AM with Nurse #5 revealed she recalled administering lorazepam 0.5 mg to Resident #29 on 05/10/13 at 2:00 PM and on 05/13/13 at 8:00 PM, which was dispensed for Resident #24. She stated there wasn't any lorazepam available in the facility's emergency supply so she called the physician and requested permission to use the lorazepam which was dispensed for Resident #24. She stated Resident #29 was extremely anxious and threatening to leave so she felt like she had to give her medication as soon as possible. When asked about the facility's policy on "borrowing"

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F 425	Continued From page 95 medication from one resident for another resident, she stated she was told it was permissible as long as the doctor was informed and consented. Nurse #5 stated narcotic medications are frequently not available in the facility's emergency supply. An interview on 06/27/13 at 5:25 PM with the Medical Director revealed he did not feel it was his decision as to whether the nurses could administer narcotic medication to a resident which was dispensed for another resident. He stated he didn't recall any instances of a nurse calling him to request permission to give a resident medication which was dispensed for another resident. He stated he didn't think it was a good practice. An interview on 06/28/13 at 4:20 PM with Nurse #6 revealed he was unclear about the facility's policy on administering medication to one resident that had been dispensed for another resident. He stated there were instances when he had to administer narcotic medications to a resident that had been dispensed for another resident. He stated it sometimes took a week to get medications refilled and that sometimes it was hard to get a refill order from the physician for narcotic medications. An interview on 06/28/13 at 5:20 PM with the Administrator revealed it was considered best practice not to administer medication to a resident that was dispensed to a different resident but that it was permissible in an emergency. She stated she expected the nurses to document the resident who was given the medication so the medication could be replaced to the resident from	F 425		

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F 425	Continued From page 96 whom it was borrowed. An interview on 06/28/13 at 5:20 PM with the Regional Nurse Consultant revealed he was not aware until a few days ago that narcotic medications for the emergency kit were not being re-ordered as needed. He stated he was in the facility 2 days a week and none of the nurses had reported a problem to him.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective 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	F 441	F441 **How the corrective action will be accomplished for the resident(s) affected.** Resident #12 nebulizer mouthpiece was replaced and put into a bag on July 1, 2013 **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The Supply clerk was educated by the Administrator on July 2 that all Oxygen Concentrators and Nebulizers had plastic bags available to store tubing when not in use. The Central Supply Staff checked all current resident with nebulizer to ensure bags were in place. **Measures in place to ensure practices will not occur.** Nursing staff was re-educated on proper oxygen equipment storage when not being utilized by the resident by the prior	7/20/13

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F 441	Continued From page 97 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, facility document reviews, staff and resident interviews the facility failed to cover the mouth piece when not in use on a nebulizer machine used to administer medication in the form of a mist into the lungs for 1 of 4 residents sampled for respiratory care and wounds. (Resident #12). The findings included: A review of a facility policy titled "Respiratory/Oxygen Equipment" dated 01/12/12 indicated in part: store oxygen tubing/mask in plastic storage bag when not in use. During an observation on 06/24/13 at 10:56 AM a nebulizer machine was sitting on top of a plastic storage container approximately 3 feet off the floor next to Resident #12's bed. A mouth piece was attached to a clip on the back of the nebulizer and the mouth piece was uncovered. During an observation on 06/24/13 at 6:00 PM a nebulizer machine was observed sitting on an overbed table next to Resident #12's bed. A	F 441	administrator and completed on July 1, 2013 **How the facility plans to monitor and ensure correction is achieved and sustained.** The Supply clerk will do weekly tubing changes and supplying each device with a new bag for storage per policy. The Leadership Team will audit Oxygen and nebulizer storage 3x per week for 2 weeks; then weekly for 2 weeks; then monthly for 2 months. The IDON will report results of audit to the QA Committee monthly for 3 months, then quarterly x 3 to ensure compliance or revisions to the plan.	

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F 441	Continued From page 98 mouth piece was attached to a clip on the back of the nebulize and the mouth piece was uncovered. During an observation on 06/25/13 at 9:35 AM a nebulizer machine was sitting on top of a plastic storage container approximately 3 feet off the floor next to Resident #12's bed. Tubing was attached to the nebulizer and was lying on top of the plastic storage container and a mouth piece was attached to a clip on the back of the nebulizer. The mouth piece was uncovered. During an observation on 06/26/13 at 10:59 AM a nebulizer machine was sitting on top of a plastic storage container approximately 3 feet off the floor next to Resident #12's bed. Amouth piece was attached to a clip on the back of the nebulizer and the mouth piece was uncovered. During an interview on 06/26/13 at 2:11 PM Nurse #1 stated she had not seen the mouth pieces covered on nebulizer machines. She further stated she sometimes found nebulizer machines sitting on the floor in resident rooms because space was limited and there was no place to store them. During an observation on 06/27/13 at 9:35 AM a nebulizer machine was observed sitting on an overbed table next to Resident #12's bed. A mouth piece was attached to a clip on the back of the nebulizer. The mouth piece was uncovered. During an interview on 06/27/13 at 9:45 AM Resident #12 stated she has bad lungs and the nurses put medication in the nebulizer machine several times a day. She explained after the nurse put the medications in the nebulizer	F 441		

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F 441	Continued From page 99 machine and turned it on she then put the mouth piece in her mouth and breathed in the medications to help her breathe better. She stated she had never seen the nurses cover the mouth piece when it was not in use and stated they put the mouth piece on a hook on the machine. During an interview on 06/27/13 at 7:47 AM the Unit Manager stated it was the facility policy for the mouth piece of nebulizers when they were not in use to be placed in a plastic bag. He further stated plastic bags were available in the supply rooms at each nursing station. He further explained there was a clip on the back of the nebulizer that held the mouth piece but it should still be covered with a plastic bag to prevent contamination. During an interview on 06/27/13 at 9:45 AM Nurse #4 stated she was the medication nurse for Resident #12. She explained Resident #12 received her nebulizer treatments at least 4 times per day and it was her routine to get Resident #12's medication out of the medication cart, put it in the nebulizer machine, turn the machine on and hand the mouth piece to the resident. She stated when the resident was finished with the medication she placed the mouth piece on a clip on the back of the nebulizer machine. She stated she had never seen the mouth pieces on any nebulizer machine covered. During an interview on 06/28/13 at 2:15 PM the Administrator stated the facility policy statement to store oxygen tubing/mask in a plastic storage bag applied to the mouth pieces for nebulizer machines. She explained the mouth piece for	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 100 nebulizer machines in resident rooms should be covered with a plastic bag when not in use and if staff saw the mouth piece uncovered they should go get a bag and cover it. During an interview on 06/28/13 at 5:15 PM the Regional Nurse Consultant stated the facility policy was to use a plastic bag to store the mouth piece when not in use. He explained there was a clip on the back of the nebulizer machine where staff could attach the mouth piece but the mouth piece should be still be covered with a plastic bag and not be left exposed. He further stated if staff saw the mouth piece was uncovered they should get a plastic bag from the supply room and cover the mouth piece but if a bag was not available they should get a new mouth piece and then cover it.	F 441		