OCT 0 3 2013

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

PRINTED: 09/27/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345191 | A. BUILDING ______ B. WING ______ | 08/22/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVINGCENTER - SURRY COMMUNITY | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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| F 000 | INITIAL COMMENTS<br><br>Amended 2567 on 9/6/2013. Tag F201 was deleted by SA.<br>Amended the 2567 on 9/27/13. Past non-compliance:no plan of correction required language was removed from the provider's plan of correction column. | F 000 | *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 159 SS=C | 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS<br><br>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.<br><br>The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)<br><br>The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br><br>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br><br>The system must preclude any commingling of resident funds with facility funds or with the funds | F 159 | F159<br>Affected residents had quarterly statements delivered to them.<br>MDS nurses will give a list of alert and oriented residents to the business office manager and the business office manager will deliver quarterly statements to those identified residents.<br>Business office manager was in-serviced immediately on proper procedure for delivering quarterly statements to alert and oriented residents.<br>Business Office Manager will supply a list of alert and oriented residents who received a quarterly statements to the ED quarterly times two with all findings will be brought to QAPI meeting for 6 months. | 10/13/13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 10-1-13

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.

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| F 159 | Continued From page 1 | F 159 | | |

of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on record review, interviews with staff and interview with alert and oriented residents the facility failed to provide quarterly bank statements to residents with whom the facility manages their funds. This was evident in 5 of 6 alert residents reviewed for personal funds. (Residents#71, #128, #132, #115 and #95)

Findings included:
Review of the business office policy and procedure dated 9/21/2011 titled " Resident Trust Fund and Valuables page 293 " Quarterly Statements " read in part:
The Executive Director will ensure that the quarterly statement, which includes an itemization and complete description of all trust activity during the quarter, is generated and issued on a quarterly basis to all residents (or authorized agents or legal representatives) for whom funds are held and managed, or as requested in writing.

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| F 159 | Continued From page 2<br><br>Review of the facility records revealed the facility managed the funds for Residents #71, #128, #132, #115 and #95 who were alert and oriented.<br><br>Review of the quarterly statements issued for January, 2013 (no exact date), April 16, 2013 and July 22, 2013 revealed the responsible parties listed on the admission record were mailed the quarterly statements. The alert and oriented residents were not provided the statement.<br><br>Interview with the business office manager on 8/22/13 at 8:35 am revealed quarterly statements are never provided to the alert and oriented residents. Further inquiry indicated that no permission was ever obtained from the alert and oriented residents to not receive their statements or provide their statements to any other person.<br><br>Interview on 8/22/13 at 9:35 am with the assistant office manager revealed for at least 7 years the facility had not been providing quarterly statements to alert and oriented residents. There was an incident that a family member complained about leaving the statements so we stopped.<br><br>Interview on 8/22/13 at 2:30 PM and 2:35 PM with 2 of the above alert and oriented residents revealed they never received a quarterly bank statement.<br><br>Interview on 8/22/13 at 2:38 pm with the administrator revealed his expectation was that alert and oriented residents be provided a quarterly statement. | F 159 | | |
| F 279<br>SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS | F 279 | | |

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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 record review, and resident and staff interviews, the facility failed to develop a Care Plan for Activities of Daily Living (ADL'S) for resident # 36 and #62 who required extensive assistance with ADL'S. This was evident in 2 of 27 residents in the survey sample. Findings include:

1. Record review indicated Resident # 62 was admitted to the facility on 10/29/13 with cumulative diagnoses of Rhabdomyolsis, Post Polio Syndrome, and Generalized Muscle Weakness.

F 279

F279
Care plan was initiated for resident # 62 regarding the need for extensive assistance for ADLs.
Care plan was initiated for resident # 36 to address the use of a splint to the left hand.
Audit to be completed on all residents who require extensive assistance with ADLs per MDS coding to ensure a care plan is in place. Audit to be completed on all residents who have an MD order for a splint to ensure a care plan is in place.
DNS or designee to monitor new admission and significant changes weekly to ensure residents who require extensive assistance with ADLs have a care plan in place addressing ADLs.
DNS or designee to monitor order by order dates at least weekly during DNS Clinical Start Up to ensure residents who have an MD order for a splint also have a care plan in place to address the splint.
All findings to be brought to QAPI x 3 months.

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| F 279 | Continued From page 4<br>The Initial CAA Assessment dated 11/05/12 indicated resident # 62 was a Short- term resident with a history of Rhabdomyolsis, Post Polio Syndrome, and Weakness. The assessment indicated the resident required extensive assistance with Activities of Daily Living (ADL'S).<br><br>The Admission Minimum Data Set (MDS) Assessment dated 11/05/12 was coded to indicate resident # 62 had no cognitive impairment. The resident had a score of 13 on the Brief Interview for Cognitive Status (BIMS Assessment), which showed the resident was cognitively intact. The MDS was also coded to indicate the resident required extensive assistance with most ADL'S, related to a diagnosis of Childhood Polio with contractures in the hands, feet, and legs.<br><br>Review of the Care Plan dated 11/05/12 indicated a Care Plan was not developed to address the resident's ADL'S.<br><br>The resident was observed on 8/21/13 at 9:30 AM in the room, in bed. The resident stated he had just received AM care, including mouth care and a shave. The resident was clean and neatly dressed.<br><br>A staff interview was conducted with MDS Coordinator # 1 on 8/22/13 at 3:30 PM. When asked the reason ADL'S were not added to the resident's current Care Plan, MDS Coordinator #1 stated, "It was overlooked at the time."<br><br>The missing portion of the Care Plan (ADL'S) was brought to the attention of the Administrator and the Director of Nurses (DON) on 8/22/13 at 5:15 PM. When asked about expectations of ADL'S | F 279 | | |

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being added to the resident's Care Plan, the DON indicated, "I expect it to be care planned."

2. Resident #36 was admitted to the facility on1/3/13 with diagnoses of hemiplegia, diabetes, and stroke.

The Minimum Data Set (MDS), an annual, dated 7/25/13 assessed Resident #36 with no impairment in range of motion of the upper extremities. This assessment included the hands. Further review of this MDS revealed no restorative care which would include splints or range of motion had been provided during the assessment period.

The care plan dated 7/25/13 did not address the use of a splint to the left hand.

Review of the current monthly orders (August) included an order for a resting hand splint to the left hand for four hours on day shift and four hours on evening shift. Day shift was to put the splint on and evening shift was to remove the splint.

Observations on 8/21/13 at 8:30 AM, 8/21/13 at 10:30 AM, 8/21/13 at 11:55 AM and 8/22/13 at 8:55 AM revealed Resident #36 did not have a splint on the left hand. The splint was located on the bedside table at the time of these

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| F 279 | Continued From page 6<br>observations.<br><br>Interview with MDS nurse #1 on 8/21/13 at 4:00 PM revealed that a care plan to address Resident # 36 ' s splint was not developed. There was not explanation as to why it had not been care planned.<br><br>Interview with the Director of Nursing on 8/22/13 at 11:42 AM revealed restorative orders would be given to the MDS nurse. Restorative would usually be included in the care plan. | F 279 | | |
| F 311<br>SS=D | 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff and resident interviews the facility failed to provide oral care for one (Resident # 131) of three sampled residents.<br><br>The findings included:<br><br>Resident # 131 was admitted to the facility on 7/19/12 with diagnoses of Diabetes and stroke.<br><br>The Minimum Data Set (MDS) dated 6/7/13 indicated Resident #131 required extensive staff assistance with bed mobility transfers and personal hygiene. This MDS assessed Resident #131 with no behaviors and no refusals of care. Resident #131 was alert, oriented and capable of being interviewed according to the MDS | F 311 | F311<br>Affected residents received immediate oral care.<br>All residents who require assistance with oral care will be identified and will be added to care sheets.<br>Staff in-serviced on oral care and the frequency at which it is to be provided. DNS or designee to perform random weekly audit to ensure residents who require assistance with oral care have been offered assistance.<br>All findings to be brought to QAPI x 3 months. | 10/13/13 |

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| F 311 | Continued From page 7<br>assessment.<br><br>The Care Area Assessments (CAAs) for activity of daily living (ADLs) dated 6/20/13 indicated Resident #131 required extensive to limited assist with ADLs. Resident #131 required assistance to stabilize during adls. The care plan team made a decision to proceed with a care plan for this care area.<br><br>The care plan dated 7/7/13 addressed a problem of physical functioning deficit related to self care impairment. The resident needed extensive assistance with adls. One of the approaches for this problem included oral care assistance would be provided by the nursing staff.<br><br>Interview with MDS nurse #1 on 8/22/13 at 10:50 AM revealed Resident #131 would require assistance with brushing his teeth. She further commented this was based on documentation by the aides for personal hygiene in the past 24 hours.<br><br>Interview with Resident #131 on 8/21/13 at 9:02 AM revealed staff had not brushed his teeth last night nor this morning.<br><br>Interview with aide #8 on 8/21/13 at 4:00 PM revealed she had worked with Resident #131. She did not brush the resident's teeth on her shift. She stated " That is done on 7-3 shift. "<br><br>Observations of care provided to Resident #131 on 8/22/13 at 9:30 AM revealed aide #2 and aide #7 went into the room to provide personal hygiene. After Resident #131 was bathed, dressed and transferred into his chair, the aides did not offer assistance or provide oral care. | F 311 | | |

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| F 311 | Continued From page 8<br><br>Interview with aide # 2 at 9:44 AM revealed the resident does his own mouth care.<br><br>Interview on 8/22/13 with aide #7 at 10:39 AM revealed she thought Resident #131 brushed his teeth himself. She was not aware he needed assistance. She had seen him brush his own teeth before.<br><br>Interview on 8/22/13 at 1:20 PM, with the aide #1 who worked with Resident #131 on 8/21/13, revealed she provided incontinence care yesterday. She did not assist him with brushing his teeth.<br><br>Interview with the Director of Nursing on 8/22/13 at 3:10 PM revealed it would be her expectation that a resident's teeth would be brushed during morning care. | F 311 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, and | F 315 | | |

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| F 315 | Continued From page 9<br>resident and staff interviews,the facility failed to maintain or restore bladder function for 2 of 3 sampled residents. Res' # 65 and # 175. Findings include:<br><br>1. Record review for Resident # 65 indicated the Medical Diagnoses on the Admission of 03/19/13 included:Late Effects of Cerebrovascular Disease, Intestinal Infections due to Clostridium Difficile, Diarrhea, Chronic Venous Embolism,Thrombosis of Deep Veins of the Upper Extremity, Hypotassemia, Edema, Constipation, Essential Hypertension, Atrial Fibrillation, and UrinaryTract Infection.<br><br>The current Minimum Data Set (MDS ) Assessment of 6/25/13 was coded to indicate Resident # 65 was cognitively intact. The Brief Interview for Mental Status (BIMS) Score was 15. The MDS was also coded to indicate Resident # 65 required Extensive Assistance with 2 plus assist for toilet use, transfers, and bed mobility. The MDS indicated the resident was frequently incontinent of bladder, and not on a Urinary Toileting program to restore bladder function.<br><br>The Care Plan initiated 3/20/13 indicated the resident was care planned for Alteration in bladder functional incontinence. The Goal was to be free of Urinary Tract Infections. Interventions included: Laboratory studies as ordered and Use of briefs/pads for incontinence protection.<br><br>Review of current medications did not indicate any specific medications for bladder.<br><br>A staff interview with MDS Nurse # 1 was conducted on 8/21/13 at 9:45 AM. When asked | F 315 | F315<br>Affected residents were immediately placed on a bowel and bladder program.<br>All new admissions will have the evaluation tool completed on admission and four current residents per week will have evaluation completed until all residents have been evaluated for bowel and/or bladder retraining program. CNAs & nurses to be in-serviced on toileting program. Nurses to be in-serviced on completing the bowel and bladder assessment completely.<br><br>DNS or designee will follow up in daily Clinical Start Up to ensure evaluations have been started and are ongoing until forms are completed.<br>Findings will be brought to QAPI times 3 months. | 10/13/13 |

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about the facility's toileting program, MDS Nurse #1 indicated, "There are no residents on a toileting program in the facility. We have added it to the QA (Quality Assurance) program and we are working on developing a program."

A Direct Care staff Interview was conducted on 8/21/13 at 12:15 PM with the assigned Nursing Assistant (NA # 5), regarding incontinent care for the resident. NA # 5 stated, "He (referring to resident # 65) is incontinent, and requires a hoyer lift for us to get him out of bed to take him to the bathroom. We check (resident #65) every two hours, and offer to take him to the bathroom. He wears briefs also. He does not tell us when he has to urinate, but does tell us when he has to have a bowel movement."

A interview was conducted with the resident on 8/22/13 at 8:20 AM. When asked if he is taken to the bathroom, the resident stated, "No,they don't take me."

A staff interview with the 200 Hall Nurse (Nurse # 5) was conducted on 08/22/13 at 8:30 AM. When asked if the resident (referring to resident # 65) could benefit from a bladder training program, Nurse # 5 stated, "Yes, I really think he could."

A Direct Care Staff interview was conducted on 8/22/13 at 8:45 AM with NA # 6. When asked if the resident could benefit from a bladder training program, the NA indicated, "Yes, I think he could really benefit from a program, so he can go to the bathroom. Therapy has been working with him. He can bear weight at times, and can stand."

A staff interview was conducted with the Director of Nurses (DON) on 8/22/13 at 5 :00 PM,

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| GOLDEN LIVINGCENTER - SURRY COMMUNITY | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

| (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 |
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| F 315 | Continued From page 11<br>regarding her expectations from the staff for improving the resident's bladder function. The DON indicated, "We needed a bowel and bladder program, and we identified it as a problem last month. We will put a program in place next Thursday (August 29, 2013)."<br><br>2. Resident #175 was admitted to the facility on 4/19/13 with diagnoses included altered mental status, subacute/acute CVA (stroke), dementia, Insulin dependent Diabetes and hypertension.<br><br>Admission assessment dated 4/19/13 of bladder function revealed the boxes for " usually continent and frequently incontinent " were both checked as " yes. " There was no toileting or retraining program/plan indicated for Resident #175.<br><br>Admission information regarding " Urinary Continence Status " dated 4/19/13 was partially completed. There were eight sections of the assessment with sections 3 and 4 completed. The summary for program placement decision was not completed. The treatment program or additional interventions for incontinence were not addressed. The signature of nurse #5 was at the bottom of the form with a date of 4/19/13.<br><br>The " Bowel Assessment Form " was blank, not signed, not reviewed and not completed.<br><br>The Minimum Data Set (MDS) dated 4/26/13 indicated Resident #175 was frequently incontinent and was not on a toileting program. | F 315 | | |

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| F 315 | Continued From page 12 | F 315 | | |

The MDS indicated Resident #175 required extensive assistance for bed mobility, transfers, personal hygiene and toileting.

The Care Area Assessments (CAAs) dated 4/26/13 indicated Resident #175 required extensive assistance for toileting, was frequently incontinent of bladder due to restricted mobility, urinary urgency and required toileting assistance.

The care plan dated 4/29/13 included a problem of physical functional deficit related to mobility impairment. The interventions included: assist in activity of daily living (ADLs), monitor ADLs for assistance and render care as needed, and assist with toileting or incontinence care as needed.

The MDS, a quarterly dated 7/19/13, indicated Resident #175 was always incontinent with no toileting program. Resident #175 was assessed as improving in bed mobility, transfer, walking and personal hygiene to limited assistance from staff. Toileting required extensive assistance from staff.

The updated care plan of 7/19/13 for ADLs and toileting remained unchanged with no new problems or strengths, goals or approaches.

Review of Care Management meeting notes dated 7/23/13 revealed Resident #175 was alert with confusion, had fair safety awareness, transfers required stand by assistance and toileting required contact guard assistance.

Interview with Resident #175 on 8/21/13 at 9:06 AM revealed staff assisted him to the bathroom. Sometimes he takes himself to the bathroom. He

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|---|---|---|---|
| | 345191 | A. BUILDING ______ B. WING ______ | 08/22/2013 |

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| GOLDEN LIVINGCENTER - SURRY COMMUNITY | 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 |

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| F 315 | Continued From page 13 | F 315 | | |

was aware when he needed to use the toilet and can ask for assistance. Further interview revealed he had not used the toilet that morning.

Observations on 8/21/13 at 9:42 AM revealed aide #2 took Resident #175 to the toilet. Resident #175 was wheeled into the bathroom, stood, and transferred himself from the wheelchair onto the commode with use of a grab bar. After a couple of minutes, aide #2 checked on the resident. At that time, he requested to remain on the commode. Resident #175 was aware of the need to have a bowel movement. Aide #2 assisted Resident #175 with peri-care and placed a disposable brief on him. Resident #175 did have a small amount of stool to pass. Interview with aide #2 on 8/21/13 at 9:42 AM revealed that was the first time Resident #175 had been toileted that morning.

Interview with MDS nurse #1 on 8/21/13 at 10:10 AM revealed the facility did not have a toileting program in place. The consultant was assisting in the formulation of a toileting plan. No projected date for roll out of toileting program. MDS nurses would be over the program. MDS nurse #1 was over the restorative program and there were no residents on restorative toileting. Resident #175 was assessed for bowel and bladder incontinence by use of the documentation completed by the aides, staff interview and resident interview. MDS nurse #1 did not review the bowel and bladder assessments completed by the floor nurses.

Interview with nurse #7 on 8/22/13 at 7:24 AM was conducted regarding the assessments for bowel and bladder on admission. Nurse #7 stated she had started the assessments on the 11-7 shift. The process for completing the

F 315 Continued From page 14 | F 315

assessments was explained. One shift will start the admission assessments, and the next shifts continue until all of the assessments were completed. Nurse #7 explained Resident #175 would sometimes ask for the urinal, or put his light on to go to the bathroom. He recently started wanting his urinal emptied. He was not consistent with using the call light or urinal. The aides on rounds either change the disposable brief or empty his urinal. When he uses his urinal, he had spillage onto the bed at times. Resident #175 was both continent and incontinent of urine.

Interview with nurse #6 on 8/22/13 at 8:44 AM revealed Resident #175 would benefit from a bowel and bladder program. He uses his urinal at times.

Interview with the Occupational Therapist (OT) who had worked with Resident #175 was conducted on 8/22/13 at 10:46 AM. The OT explained Resident #175 would be discharged from therapy due to inability to dress his lower body. The goals were met and nursing would have to provide the assistance he needed. The OT plan included writing a restorative nursing plan of care for upper body exercises and toilet transfers. During the interview, the OT was asked about Resident #175 ' s ability to assist with toileting. She explained he would need assistance for personal hygiene. Resident #175 was able to tell you he had to go to the bathroom and was able to use the call light. He would benefit from a scheduled toileting program.

An interview was conducted with the Director of Nursing on 8/22/13 at 5:00 PM, regarding her expectations from the staff for improving the

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| F 315 | Continued From page 15<br>resident's bladder function. She indicated, "We needed a bowel and bladder program, and we identified it as a problem last month. We will put a program in place next Thursday (August 29, 2013)." | F 315 | | |
| F 318<br>SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review the facility failed to follow therapy recommendations for restorative range of motion for one of one sampled residents with recommended restorative range of motion. Resident #36.<br><br>Findings included:<br><br>Resident #36 was admitted to the facility on 1/3/13 with diagnoses of hemiplegia, diabetes, and stroke.<br><br>The Minimum Data Set (MDS) dated 7/25/13 assessed Resident #36 with no impairment in range of motion of the upper extremities. Further review of this MDS revealed no restorative care for range of motion had been provided during the assessment period. | F 318 | F318<br>Affected residents were placed on restorative nursing and care plan was updated to reflect restorative nursing.<br>An audit will be completed of all current residents who were discharged from therapy from 01/01/2013 - 04/30/2013 to ensure no therapy recommendations for restorative nursing were missed.<br>A new process was implemented 05/01/2013 for communication between therapy and nursing. The communication form is used by therapy and instructions are hand written for restorative nursing care.<br>As of 09/06/2013, the form now requires the signature of the Director of Rehab, the restorative staff member trained and the MDS nurse.<br>DNS or designee to complete monthly audit to ensure that residents who are discharged from therapy and have recommendations for restorative nursing have been addressed. Findings to be reported to QAPI x 3 months. | 10/13/13 |

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| F 318 | Continued From page 16 | F 318 | | |

The care plan dated 7/25/13 did not address restorative nursing to maintain functional range of motion to the upper extremities.

Review of the monthly orders for August 2013 revealed an order for splint application to the left hand. There were no orders for range of motion to the upper extremities to be provided by restorative nursing.

Interview with the occupational therapist (OT) on 8/21/13 at 12:18 PM revealed Resident #36 was discharged from therapy on 3/29/13. According to the therapy progress notes dated 3/29/13, recommendations from therapy to nursing included the following:
- nursing to maintain progress with range of motion of the bilateral upper extremities and prevent progression of contractions to fingers of the left hand.
- nursing to provide passive range of motion exercises of both shoulders and hands and use a left resting hand splint for 8 hours a day.

Continued interview revealed the process for recommendations from therapy to nursing included printing the progress note from the computer documentation. The progress note would be given to the nurse supervisor of restorative nursing. Since the arrival of a new therapy manager, the communication process had changed. Changes included use of a hand written form from therapy to restorative nursing. The time of implementation was about May 2013. Prior to that time, she could not account for what might have happened with the computer printed copy of therapy recommendations for restorative nursing.

Interview with MDS nurse #1 on 8/22/13 at 4:00

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| F 318 | Continued From page 17<br>PM revealed she supervised the restorative program. Resident #36 had not received restorative nursing since April to August 2013. She explained a referral from therapy for restorative nursing had not been communicated to her. The new therapy director had implemented a process for communication between therapy and nursing. A form would be used by therapy, and instructions were hand written for restorative nursing care. The new from began when the therapy manager started working, which was around May of this year.<br><br>Interview on 8/22/13 at 3:00 PM with the Director of Nursing revealed Resident #36 should have received restorative nursing after therapy had written the recommendations. | F 318 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 09/20/2013
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|
| | 345191 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 09/17/2013 |

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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 02249<br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V(111) construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | RECEIVED OCT 07 2013 CONSTRUCTION SECTION<br><br>**Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.** | |
| K 018 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by: | K 018 | K 018<br>SS = D<br><br>**Criteria 1**<br>Door to the rooms 207 and 401 were adjusted to ensure that when doors close, they latch. The Maintenance Director was educated regarding self closing, fire-rated doors.<br><br>**Criteria 2**<br>All other facility fire-rated doors were inspected to ensure self-latching when closed.<br><br>**Criteria 3**<br>The Maintenance Director or Administrator in his absence, will monitor 6 fire rated doors weekly to ensure self-latching. Any doors found out of compliance will be corrected immediately.<br><br>**Criteria 4**<br>The results from the monitoring will be brought to the QAA committee to monitor regulatory compliance monthly X 3 months or until no longer deemed necessary. | 11-1-13 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 10-3-13 |

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


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| | 345191 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 09/17/2013 |

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| K 018 | Continued From page 1<br>Surveyor: 02249<br>Based on observation, on September 17, 2013 at approximately 10:00am onward, doors to the following rooms would not latch in the closed position:<br><br>1. resident room 207<br><br>2. resident room 401<br><br>42 CFR 483.70(a) | K 018 | | |
| K 067<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on September 17, 2013 at approximately 10:00am onward, there is no return air inlet in the conference room. The corridor may not be used as aretum air plenum.<br><br>Note: Mechanical outlets/inlets shall be equipped with ceiling fire dampers installed in accordance with the manufacturer's installation instructions.<br><br>42 CFR 483.70(a) | K 067 | K 067<br>SS = D<br><br>**Criteria 1**<br>Return air inlet was placed in affected area.<br><br>**Criteria 2**<br>Facility will identify other rooms and provide return air inlets in those rooms.<br><br>**Criteria 3**<br>Any future changes to the facility, Maintenance Director will ensure that those rooms have return air inlets as well.<br><br>**Criteria 4**<br>The results from the monitoring will be brought to the QAA committee to monitor regulatory compliance monthly X 3 months until no longer deemed necessary. | 11-1-13 |