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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 9/12/2013. Event ID# Z0RF11.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156	1. Resident #24 and Resident #44 could of been offected by this deficient practice The facility will provide a liability and appeal notice prior to discharge of Medicare services to ensure that the resident and/ or responsible party has the right to have a claim or demand bill submitted to Medicare. 2. All residents could of been effected by this deficient practice. The facility will ensure that all residents and/or responsible parties are provided a liability and appeal notice prior to discharge of Medicare services to ensure they have the right to have a claim or demand bill submitted to Medicare. 3. Kalee Biaz, administrative assistant is to be in-serviced by Caroline Horne, RN, Administator to provide all residents and responsible parties a liability and appeal notice prior to discharge of Medicare services to ensure they have the right to have a claim or demand bill submitted to Medicare. Continued on next page	9/12/13 9/12/13 9/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Caroline Horne, [illegible] TITLE: Administrator (X6) DATE: 10/29/13

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 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility	F 156	continued from previous page 4. LaDean Hair, RN, QA will ensure that all resident's and responsible parties are provided a liability and appeal notice prior to discharge of Medicare services to ensure they have the right to have a claim or demand bill submitted to Medicare by using new QA form titled "liability and appeal notice audit" will audit weekly x's 90 days then monthly on an ongoing basis.	10/21/13

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F 156	Continued From page 2	F 156		

written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide a liability and appeal notices to 2 of 3 sampled residents who were discharged from Medicare services (Resident # 24 and Resident # 44). The findigs included:

A review of the liability form titled "notice Medicare Provider Non-Coverage" revealed Resident #24 and Resident #44 were not provided notification by the facility of the residents' right to have a claim or demand bill submitted to Medicare.

During the interview on 9/12/2013 at 2:00 PM, the receptionist reported that she was responsible for providing the Liability Notice forms to the families and the residents at the facility. She added that Resident # 24 and Resident # 44 were not provided with the Liability Notice forms because she was not aware that the residents were required to sign the forms.

During the interview with Administrator on 9/12/2013 at 2:20 PM, she reported that she was not aware that the facility was required to provide the Liability Notice forms to the residents who were being discharged home after receiving Medicare services. She further added that the

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F 156	Continued From page 3 facility will begin to provide the Liability Notice forms to all residents who were being discharged home, as long as they had been discharged from Medicare services.	F 156		
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.	F 157	1. Resident #18 could of been effected by this deficient practice. The facility will promtly notify the physician and responsible party of any accidents involving the resident which results in injury and has the potential for requiring physician intervention. 2. All residents could of been effected by this deficient practice. The facility will promptly notify the physician and responsible party of any accidents involving the resident which results in injury and has the potential for requiring physician intervention. 3 (a) All nurses will be in-serviced by Caroline Horne, RN,Administrator and Deborah Spell,RN,DON to promptly notify the physician and responsible party of any accidents involving the resident which results in injury and has the potential for requiring physician intervention. 3 (b) All nurses will be in-serviced by Caroline Horne, RN,Administrator and Deborah Spell,RN,DON on skin tears and laceration standing orders and protocols. Continued on next page	9/13/13 9/13/13 9/23/13 9/10/13

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F 157	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to notify the physician for 1 of 2 residents (# 18) reviewed for accidents that sustained a laceration to the hand that required medical evaluation. The findings included: Resident # 18 was admitted to the facility on 9/21/2010 with medical diagnoses which included anemia and CVA (Cardiovascular Accident). Review of the facility skin tear protocol updated 10/14/2011 indicated "skin tear protocol will be part of the physician's standing order and used unless otherwise specified by the attending physician. Skin tear protocol stated "Cleanse skin tear with normal saline. Apply tegaderm according to the size of skin tear. Check skin tear everyday, change tegaderm every 5-7 days and prn (as needed) until healed. For large skin tear or skin tear with copious drainage may clean with normal saline, use Steris trips if needed and cover with dry dressing. Change prn until healed. Review of the Minimum Data Set (MDS) dated 7/4/2013, indicated Resident #18 was severely cognitively impaired. Review of an incident report for Resident #18 dated 9/4/2013 at 11:45 pm indicated the resident received a laceration to the index finger on the right hand. The Nurse's descriptive note stated "Resident resistant to ADL care-grabbing the bed rail-skin tear to right pointer finger at the base of finger." Review of a physician's telephone order dated	F 157	4. LaDean Hair, RN,QA will audit all accidents including but not limited to skin tears and lacerations to ensure physician and responsible parties are noticed promtly if involving a resident which results in injury that has the potential for requiring physician intervention using new QA form titled "accidents resulting in injury" daily x' 30 days then weekly on an ongoing basis.	9/30/13

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F 157	Continued From page 5 9/4/2013 indicated "Cleanse skin tear to right pointer finger at base of finger with normal saline. Pat dry. Apply (TAO) triple antibiotic ointment cover with nonstick dressing wrap with kling. Change daily until healed." Review of a physician's telephone order dated 9/5/2013 untimed indicated "May send to urgent care clinic at Hospital #1 or to Hospital #2 ER (Emergency Room) for stitches to right index finger base, unable to maintain closure to this moveable joint with steristrips or dressing." Review of the hospital Express Care Record for Hand/Wrist Injury sheet dated 9/5/2013 revealed a wound description of 2.5cm laceration to the right hand index finger. The narrative notes on the hand/wrist injury sheet indicated "wound older than 8 hours. Cleaned and dressed. Wound must be rechecked in 3 days." During a phone interview with Nurse #3 on 9/10/2013 at 3:48 pm, she stated "resident had a gash. I could not tell how deep. There wasn't much blood. I passed it on to the treatment nurse the next day that the area may need more treatment. I didn ' t know if it needed stitches or Steris trips." Nurse #3 indicated she did not call the physician because it was not an emergency. In an interview on 9/10/2013 at 3:57 pm, the Director of Nursing (DON) indicated her expectation was for the nurse to call the doctor for an injury that required a treatment that was not included in the standing order protocol or that could not be provided in the facility. During an interview with the Charge Nurse on 9/11/2013 at 10:40 am, she stated her	F 157		

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F 157	Continued From page 6 observation of the wound was that the wound possibly needed stitches and she notified the physician immediately on 9/5/2013 at 10:30am and obtained an order to send the resident out for medical evaluation and treatment. In an interview with Nurse # 3 on 9/12/2013 at 7:30 am, she stated she notified the physician of the incident report on 9/5/2013 at 7:30 am via fax machine. During a phone interview with the Attending Physician on 9/12/2013 at 9:55 am, he stated his expectation was for the nurse to call the doctor on call for anything that was not listed in the protocol. The Attending Physician stated "In this situation, she should have called whoever was on call. We are on call 24 hours a day, 7 days a week."	F 157		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	1. All residents could of been effected by this deficient practice. The facility will ensure that all expired vials and ampules of injectable medications are removed from active stock for residents use and promptly disposed properly 2. All residents could of been effected by this deficient practice. The facility will ensure that all expired medications are removed from active stock for resident use and returned to the pharmacy promptly for disposal. Continued next page	9/13/13 9/13/13

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F 431	Continued From page 7 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review, the facility failed to remove two vials of stock supply of Pneumonia Vaccines from use in one of two medication refrigerators. The findings included: Review of the facility policy guidelines entitled Vials and Ampules of Injectable Medications dated January 1, 2008 indicated medication in multidose vials may be used until the manufacturer's expiration date/ for the length of time allowed by state law/according to the facility policy for thirty days if inspection reveals no problems during that time. On 9/10/2013 at 11:35 am, one medication refrigerator on the Alzheimer's Unit was observed to contain the following: Two vials of Pneumonia Vaccines	F 431	3. All nurses will be in-serviced by Caroline Horne,RN,Administrator and Deborah Spell RN,DON on the policy and procedure of expired medications and proper disposal of expired medications. 4.(a) LaDean Hair,RN,QA will ensure that all expired medications are removed from active stock for resident use and returned to the pharmacy for disposal by using new QA form titled "expired medication removal and disposal" weekly x's 90 days then monthly on an ongoing basis. 4.(b) Southern Pharmacy will notify LaDean Hair, RN,QA of any expired medications found on pharmacy rounds in residents active stock to ensure proper removal and disposal on an ongoing basis.	9/23/13 9/30/13 10/01/13

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F 431	Continued From page 8 dispensed on 8/9/2012 with a manufacturer's expiration date of 8/5/2013. The medication was in active stock for resident use. In an interview with Nurse #5 on 9/10/2013 at 11:40 am, she indicated she recalled the consultant pharmacist had marked the box with the expiration date for the vials to be removed in August but it was overlooked. Nurse #5 indicated the medication was expired and should have been discarded. During an interview with the Director of Nursing on 9/12/2013 at 11:47 am, she stated her expectation was for the licensed nursing staff to remove expired medications from storage and return them to the pharmacy for disposal.	F 431		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to validate Nursing Assistant II (NAII) skill competency level prior to performing wound care on the facility residents for 2 of 2 NAII's (NAII #1, NAII #2). The findings included: 1. Resident # 18 was admitted to the facility on 9/21/2010 with medical diagnoses which	F 498	1. All resident's could of been effected by this deficient practice. The facility will ensure that all CNA II's skill competency level will be validated prior to performing wound care on facility residents. 2. All resident's could have been effected by this deficient practice. The facility will ensure that all CNA II's skills competency level will be validated prior to performing wound care on facility residents and ensure that all CNA II's have a skills and performance checklist to prove that the CNA II's skills competency level has been validated.	9/23/13 9/23/13

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F 498	Continued From page 9 included CVA (Cardiovascular Accident), psychosis and Alzheimer's disease. A review of a telephone physician order dated 9/5/2013 indicated to "clean right index finger daily with soap and water, then dry. Apply bactroban three times a day." A review of a telephone physician order dated 9/8/2013 indicated "wound dressing to right hand need to be covered with a 2 by 2 gauze, secured with Kling wrap around the finger and around the hand. Cover the dressing with open finger mesh or glove or gerisleeve." A review of a telephone physician order dated 9/11/2013 indicated "change treatment to right index finger to clean wound with soap and water, pat dry. Apply hydrogel AG (silver). Cover with collagen and nonstick dressing, wrap around kling around the hand and second finger and cover the dressing with mesh or glove or gerisleeve." A review of the Treatment Administration Record (TAR) revealed the signature of Nursing Assistant II (NAII) #1 on four entries, 9/6/13 for the 7-3 and 3-11 and on 9/9/13 for the 7-3 and 3-11 shifts. A review of the facility's undated skills and performance checklist for Nursing Assistant II indicated NAII skills should be validated by an LPN (Licensed Practical Nurse) or a RN (Registered Nurse). During an observation of wound care for Resident #18 on 9/11/2013 at 12:20 pm,	F 498	3. Robin Starling, LPN,Wound Care and LaDean Hair, RN,staff development will be in-serviced by Caroline Horne,RN, Administrator and Deborah Spell,RN, DON that all CNA II's skills competency level must be validated. This validation must be proved by using a skills and performance checklist.	9/23/13
			4.(a) LaDean Hair,RN,QA will ensure that on hire all CNA II's competency level and skills are validated using the skills and performance checklist on an ongoing basis This checklist are to be placed in each CNA II's permanent employee record.	9/23/13
			4(b) Robin Starling, LPN, Wound care nurse will monitor the CNA II's skills, competency and performance on an ongoing basis.	9/23/13
			4.(c) LaDean Hair, RN, QA will ensure that on hire all CNA II's are properly trained by a nurse. Also that all CNAII's competency level and skills are validated using the skills and performance checklist by using new QA form titled "CNA II's validation and performance checklist" to be done on all new CNAII's on date of hire and on an ongoing basis.	10/21/13

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NAII #1 started in the room with Hydrogel. The physician's order dated 9/11/2013 stated Hydrogel AG (silver). NAII #1 confirmed with Nurse #1 that Hydrogel was not the same product as Hydrogel AG.

A review of the employee file for NAII #1 did not reveal a signed copy of the facility's checklist for skills and performance for NAII.

During an interview on 9/11/2013 at 12:35 pm, NAII #1 indicated she was trained by NAII #2. She further indicated she signed the TAR for Resident #18 on 9/6/13 7-3 and 3-11 and 9/9/13 7-3 and 3-11 shifts but she did not perform the treatment as ordered. NAII #1 stated she checked the dressing to see if it was dry and intact as she had been instructed to do. NAII #1 indicated she could not recall who had given her the instructions to check the dressing.

In an interview on 9/11/2013 at 12:50 pm, NAII #2 stated she trained NAII #1 on wound care but she was not able to complete the last day of the training due to conflicts in the schedule. NAII #2 further indicated she was trained on wound care by another NAII.

On 9/11/2013 at 1:10 pm, the administrator was unable to provide evidence of validation of skills and performance for NAII #1. The Administrator further indicated a signed copy of the NA II skills and performance checklist should be filed in the employee file jacket.

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F 498	Continued From page 11 During an interview on 9/12/2013 at 11:10 am, NAII #1 indicated she was trained to sign off on the treatment orders for the 3-11 shift and it was understood that someone else would do the treatment later. NAII #1 stated "I am confused and don't know what I should and should not be doing." During an interview on 9/12/2013 at 11:31 am, Nurse #1 stated the NAII's were trained by other NAII's that had worked in the treatment aide position. In an interview with the Administrator and Director of Nursing (DON) on 9/12/2013 at 11:49 am, the DON stated the skills and evaluations performance checklists should have been signed off by the treatment nurse for the NAII's. 2. Review of the facility's undated skills and performance checklist for Nursing Assistant II ' s (NAII) indicated NAII skills should be validated by an LPN (Licensed Practical Nurse) or an RN (Registered Nurse). A review of the employee file for NAII #2 did not reveal a copy of the facility's skills and performance checklist for NAII. In an interview on 9/11/2013 at 12:50 pm, NAII #2 stated she was trained on wound care by another NAII in the treatment aide position. During an interview on 9/12/2013 at 11:31 am, Nurse #1 stated the NAII's were trained by other NAII's that had worked in the	F 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

(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 498	Continued From page 12 treatment aide position. In an interview with the Administrator and Director of Nursing (DON) on 9/12/2013 at 11:49 am, the DON stated the skills and performance checklist should have been signed off by the treatment nurse for the NAII's.	F 498		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the clinical record reflected care provided to an unstageable pressure ulcer for 1 of 5 residents reviewed for pressure ulcers (Resident #17). The findings included: Resident #17 was admitted into the facility on 9/12/12. Diagnoses included Pressure ulcer and Diabetic Neuropathy. A significant change minimum data assessment completed on 6/14/13	F 514	1. Resident #17 could of been effected by this deficient practice. The facility will ensure that the TAR (treatment administration record) is signed when treatments are completed or an explanation will be provided on the back of the TAR if treatment was not completed. 2. All resident's could of been effected by this deficient practice. The facility will ensure that the TAR is signed when treatments are completed or an explanation will be provided on the back of the TAR if treatment was not completed. 3. All nurses and CNA II's will be in-serviced by Caroline Horne, RN, Administrator and Deborah Spell RN,DON on the policy and procedure on treatments and documentation. Also, in-serviced that a TAR must always be signed when a treatment is completed. If a treatment is not completed an explanation must be written on the back of the TAR. Continue on next page	9/13/13 9/13/13 9/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING ____ B. WING ____	C 09/12/2013

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BETHESDA HEALTH CARE FACILITY	3532 DUNN ROAD EASTOVER, NC 28301

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F 514	Continued From page 13 indicated that Resident #17's mental status was severely impaired. Total dependence on the staff was required with activities of daily living. One unstageable pressure ulcer was indicated that measured 1 cm (centimeter) length x 1 cm width. The care plan date 6/18/13 listed an unstageable pressure ulcer to the right toe as a problem area. Approaches to care read in part "monitor skin during care and report changes to treatment nurse, treatments as ordered." A review of the treatment administration record (TAR) for September 2013 read "1) apply polysporin powder topically to right second toe dorsal aspect wound bed after cleaning with normal saline daily. 2) Apply santyl ointment nickel thick layer to same area (second toe) dorsal aspect after polysporin. Cover with hydrogel gauze, then border foam clean first with normal saline, change every day as one treatment." Further review of the TAR for September 2013 revealed treatment to the right second toe was not signed as completed nor an explanation provided on the back of the TAR from 9/1/13 through 9/9/13. A review of the weekly skin assessment revealed no clinical notation regarding the specific care provided to the ulcer to the second right toe from 9/1/13 through 9/9/13. In an interview on 9/10/13 at 11:00 am Nurse #1 indicated that she oversaw ulcer treatments and that she was not sure why the TAR was not signed to reflect the care provided. She concluded that she was not aware until today.	F 514	4. LaDean Hair, RN, QA will ensure that all TAR's are completed, accurately documented, readily accessible and systematically organized. LaDean Hair, RN,QA, will use new QA form titled "TAR audit" to ensure that all treatments completed are signed or an explanation is provided on the back of the TAR if treatment was not completed. New form to be done weekly x's 90 days then monthly on an ongoing basis.	9/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345212	A. BUILDING ______ B. WING ______	C 09/12/2013

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F 514	Continued From page 14	F 514		

In an interview on 9/10/13 at 11:15 am nursing assistant II (NA II) #1 acknowledged that she worked 9/3/13 through 9/6/13 and forgot to sign off on the TAR that she completed ulcer care to the second right toe.

In an interview on 9/10/13 at 2:45 pm Nurse #2 acknowledged that she worked on 9/8/13. She stated that she thought she performed the treatment to the right toe but was not sure. She indicated sometimes Resident #17 refused the treatment to be done. If so, she would have documented on the back of the TAR that the resident refused.

In an interview on 9/10/13 at 2:55 pm NA II #2 acknowledged that she worked on 9/1/13 and 9/7/13. She indicated she forgot to initial on the TAR that she provided ulcer care to the second right toe.

In an interview on 9/10/13 at 3:00 pm the administrator concluded that she expected the clinical record "treatment administration record" to have been signed each day to reflect the care provided by the nursing staff.

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

PRINTED: 10/25/2013
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
	345212	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building 0102 is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation the following exit egress was non-compliant, specific findings include; the door exiting the kitchen to the exit corridor had a dead bolt that required more than one range of motion to exit the area. Doors shall be operable with not more than one releasing operation.	K 038	**K 038** **1. All residents, staff, and visitors could have been effected by this deficient practice The facility will ensure that all doors that exit into a exit corridor that have a lock must be readily accessible at all times using a lock with no more than a single/one releasing operation.**	**10/29/13**
			2. All residents, staff, and visitors could have been effected by this deficient practice. The facility will ensure that all doors that exit into a exit corridor are readily accessible at all times. All doors must be operable with not more than a single/one releasing operation	**10/29/13**
			3.(a) Neal Walker, Maintenance supervisor and LaDean Hair, RN, Quality Assurance have been in-serviced by Caroline Horne, Administratornthat all exit accesses are arranged so that exits are readily accessible at all times. All doors shall be operable with no more than a single/one releasing operation	**10/25/13**
			3.(b) Neal Walker, Maintenance supervisor has replaced the lock on the door exiting the kitchen to the exit corridor with a lock that operatesn with a single/one releasing operation.	**10/29/13**
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	**4. LaDean Hair, Quality Assurance will ensure that all doors with locks exiting into a exit corridor, unlock using a single/one releasing operation using the new QA form monthly on an ongoing basis titled "proper door locks."**	**10/29/13**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Caroline Horne Adm	Administrator	11/19/13

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345212	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/25/2013

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K 047	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation the following exit and directional signs were non-compliant, specific findings include; the exit signs #3, #8 and #11 were turned in the incorrect position. Each exit sign was correctly rotated to the correct position during the survey.	K 047	K 047	
			1.All residents, staff, and visitors could have been effected by this deficient practice The facility will ensure that all exit signs are positioned correctly.	10/29/13
			2. All residents, staff, and visitors could have been effected by this deficient practice. The facility will ensure that all exit signs are positioned correctly .	10/29/13
			3.(a) LaDean Hair, Quality Assurance and Neal Walker, Maintenance supervisor was in-serviced by Caroline Horne, Administrator that all exit signs must be positioned in the correct position at all times 3.(b) Neal Walker, Maintenance supervisor	10/25/13
			ensured all exit signs are positioned in the correct position and bolted to prevent exit signs from rotating in an incorrect position	10/28/13
			4. LaDean Hair, Quality Assurance will check monthly that all exit signs are positioned correctly on an ongoing basis using new QA form titled " exit sign position"	10/29/13