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FORM APPROVED
OMB NO. 0938-0391

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
	345089	A. BUILDING ______ B. WING ______	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL ST WALNUT COVE, NC 27052

(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 2567 amended on 2/20/14	F 000		
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	F 157	F 157 1. The family of Resident # 16 was notified of the resident's weight loss on 10/21/2013. 2. All resident charts of residents experiencing weight loss were reviewed to ensure there was documentation of the notification of the responsible parties of unplanned weight loss. There were no new issues related to timely notification of responsible parties of unplanned weight loss found during this audit. The Director of Nursing and the Dietary Manager have been re educated by the Regional Director of Clinical Services concerning the notification of the resident and/or the responsible party of any unplanned weight loss.	12/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda M. Byers
TITLE: Administrator
(X6) DATE: 2-20-14

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 157	Continued From page 1 by: Based on record review, interview with a family member and interview with staff the facility failed to notify a family member when Resident #16 experienced weight loss. This was evident in 1 of 4 residents in the sample reviewed for nutrition. Finding included: Resident #16 was admitted on 7/9/13 with cumulative diagnoses which included bilateral fractured ankles with open reduction and internal fixation due to a fall. Review of the discharge summary from the hospital undated with a discharge date of 7/2/13 revealed Resident #16 was on Hospice for co-morbidities. Review of the Minimum Data Set (MDS) assessment dated 7/14/13 revealed the resident was alert and oriented at the time of admission but required extensive assistance for staff for all activities of daily living especially for turning and repositioning, Record review revealed Resident#16 ' s height was 67 inches tall and a weight history as: 07/09/2013 208 pounds (lbs) on admission 08/04/2013 191 lbs The resident experienced an unavoidable weight loss of 17 lbs or an 8.2% loss in less then one month. There was no documentation in the medical record that indicated the responsible party was notified of the weight loss. Interview on 11/19/13 at 3:35 PM via the phone with a family member of Resident #16 revealed the staff had not notified them of the residents'	F 157	**F 157 (cont.)** 3. The Director of Clinical Services or Unit Manager will monitor this process by documenting the notification of weight loss on the Weight Loss monitoring tool that will be filled out weekly on Wednesday when the report of standards of care is due to the Regional Director of Clinical Services. This will be documented weekly x 4 weeks, every other week x 8 weeks, and then monthly x 9 months. 4. The Director of Clinical Services will report the findings of the monitoring to the Quality Assessment and Assurance committee meeting each month for 12 months for review and recommendations from the committee. 5. AOC 12/20/2013	12-20-13

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F 157	Continued From page 2 weight loss Interview on 11/21/13 at 8:30 AM with the director of nurses (DON) revealed she could not find any documentation to support the responsible party was notified. Interview on 11/22/13 at 7:20 am with the DON revealed the previous food service manager (who was responsible for notifying the family about weight losses) was no longer employed at the facility as of August 2013. The DON indicated the responsibility then became nursing to notify the family. Additionally, the DON indicated she started (no exact date provided) the responsibility of reviewing the weights and notifying the family about the weight loss. The DON revealed she did not notify Resident #16 ' s family about this weight loss.	F 157	**F 248** 1. The activity care plans for residents #20 and #73 were reviewed by the Activity Director. Amendments were made to ensure that these residents receive one on one scheduled activities and include them in special focus groups designed to prevent falls. 2. All residents care plans for residents who are severely cognitively impaired were reviewed by the Activity Director to identify the individual expectations for each resident. Any care plan that did not include appropriate interventions were updated. The Activity Director was re-educated by the Executive Director concerning the requirement that the care plans for each resident with severe cognitive impairment must be followed as written for each resident and that activity logs must be completed daily.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident observations, interviews with staff, and record reviews the facility failed provide activities as noted in their plans of care for 2 of 3 severely cognitively impaired residents (#20 and #73) reviewed for activities. The findings include: 1) Resident #20 was admitted to the facility	F 248		12/20/13

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F 248	Continued From page 3 09/18/2007 and had diagnoses which included Congestive Heart Failure, Hiatal hernia, Depression, Dizziness, Insomnia, Anxiety, Depression, Lower extremity edema, Hypertension, Cardio Obstructive Pulmonary Disease, Esophageal reflux, a history of a right wrist fracture, Chronic Cystitis, a history of a left hip fracture, Dementia w/behaviors, Severe Acute Respiratory Syndrome, Restless Leg Syndrome, Decreased and Lack of coordination, Difficulty walking, Dysphagia, and Abnormal Posture. The resident's quarterly Minimum Data Set (MDS) dated 09/09/2013 indicated the resident to be severely cognitively impaired. A Basic Interview of Mental Status (BIMS) could not be completed due to the resident ' s cognitive impairment. The MDS also indicated the resident needed extensive to total assistance of 1 to 2 staff to perform Activities of Daily Living (ADLs). The resident's Care Plan (CP) dated 08/25/2009 with a most recent update on 04/23/2013 indicated the resident as having - Mental inability to participate in activity programs related to impaired thought processes. The facility documented the goal for this problem to be - Resident will participate in at least 2 - 4 activities per week through the next review. The CP documented interventions and the facility would - Take resident out of room to activities, assist resident to church activities 2 - 4x weekly, conduct individual 1:1 activities (reading and singing) 1x a week, engage resident in group activities, establish a daily routine with same activity personnel/volunteers, offer ongoing structured activities, and provide passive activities. An initial observation was made of resident #20 on 11/17/2013 at 12:44 p.m. during the facility tour. The resident was in her room lying in her	F 248	**F 248 (cont.)** 3. The activity logs will be reviewed by the Executive Director for completion and adherence to the care planned activities for the severely cognitively impaired residents. The Documentation of Activities for Severely Impaired Residents monitoring tool shall be used to ensure compliance. Monitoring results shall be reviewed at each morning Department Head meeting each day for 5 days; 3 morning meetings a week for 3 weeks; 1 morning meeting a week for 4 weeks and then 1 morning meeting a month for 10 months. 4. The Executive Director will report the results of the monitoring to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC 12-20-13	12-20-13

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F 248	Continued From page 4 bed. There was no activity observed being conducted with the resident. Three additional observations were conducted between 1:30 p.m. and 4:30 p.m. The resident was not observed out of bed or to have any in room 1:1 activities provided. On 11/18/2013 multiple observations of the resident were made at 8:36 a.m.; 9:41 a.m.; 11:10 a.m.; and 2:55 p.m. No activities were observed (1:1 activity, exercises, music therapy, etc.) being conducted with the resident who remained in her room in bed and in her wheelchair at the bedside. On 11/19/2013 multiple observations of the resident were made at 7:30 a.m.; 8:55 a.m.; 10:22 a.m.; 12:20 p.m.; 1:48 p.m. and 3:22 p.m. No activities were observed being conducted with the resident who remained in her room in bed. On 11/20/2013 multiple observations were made of the resident at 9:00 a.m.; 10:10 a.m.; 11:15 a.m. No activities were observed being conducted with the resident who remained in her room in bed at the 7:30 a.m. and 8:55 a.m., in her wheelchair at 10:22 a.m., 12:20 p.m., and 1:48 p.m. at the bed side then back in her bed at 3:22 p.m. An interview was conducted with the Activities Director on 11/20/2013 at 11:30 a.m. concerning activities conducted with facility residents. The activities director indicated she had monthly and daily activity logs to indicate which residents received or attended activities and the Assistant Activities Volunteer had 1:1 activity logs indicating which residents received 1:1 and in room activities. The activities director indicated that she had been without an activities assistant since the end of October but just hired an activities assistant yesterday (11/19/2013) and hoped the logs the Assistant Activities Volunteer had been keeping were current and had been updated.	F 248		

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F 248	Continued From page 5 The Activity Director indicated there was no monthly activity log for November 2013 showing what activities the residents participated in. The Activities Director provided daily activity logs for November 2013 which indicated by checks, asterisks, or other marks which residents attended or received in or out of room activities. A review of the November daily resident activity log sheets from 11/06/2013 through 11/19/2013 was conducted. There were no logs for November 1st, 4th, or 5th. The Activities Director indicated she did not know where the sheets for those dates were or if they had any. The reviewed daily resident activity logs for November revealed there were no entries or documentation to indicate resident #20 received any activities during the month of November 2013 (last 20 days). The Activities Director again indicated there was no monthly activities log for November 2013 and she could not find any daily resident activity logs during November which indicated resident #20 received any form of activity. The Activities director indicated there were no other monthly, daily or 1:1 activity sheets for November 2013 kept in any other location except the Activities Assistant Volunteer may have some on her desk or in her notebook. An interview with the Assistant Activities Volunteer was conducted on 11/20/2013 at 12:05 p.m. The assistant volunteer indicated she filled out and was responsible for documenting the resident daily activity log sheets and the daily 1:1 activity log sheets which she kept at her desk in her notebook. The Assistant Activities Volunteer looked on her desk and in her notebook then indicated she did not recall doing any 1:1 exercises, music or other type activity with resident # 20 during the month of November	F 248		

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F 248	Continued From page 6 2013. During the interview the Activities Director asked the Assistant Activities Volunteer if she had logged any activities with resident #20 during the first 3 weeks of November. The Assistant Activities Volunteer indicated she had talked to the resident several times in the halls but did not spend at least 15 minutes with the resident at any time as she had been instructed that talking to the resident in the hall did not count as an activity and not spending at least 15 minutes with the resident doing an activity did not count and could not be logged. The Assistant Activities Volunteer indicated she could not remember doing any 1:1 activities with resident #20. An observation was made of the Assistant Activities Volunteer reviewing her notebook and the documented 1:1 activity sheets and daily activity sheets for November a second time. Resident #20's name was not listed on any of the 1:1 activity sheets (June through October 2013) as having any 1:1 activities conducted with her. The Assistant Activities Volunteer indicated there were no documented 1:1 activities for resident #20 during the months of June through October 2013 and there was no 1:1 activity sheet for November 2013 as she had not done one for November 2013. The most recent 1:1 resident activity sheet found by the Assistant Activity Volunteer and observed/reviewed was dated 10/23/2013. The Assistant Activity Volunteer did find the 3 previously missing daily resident activity log sheets dated November 1st, 4th, and 5th. A review of the 3 resident daily activity log sheets revealed resident #20 was not documented as receiving any activity on these days. The Assistant Activities Volunteer indicated the resident didn't have any activities thus far in November as far as she knew.	F 248		

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F 248	Continued From page 7 2) Resident #73 was admitted to the facility on 03/07/2013. The resident's diagnoses included a history of falls, Hyperlipidema, Chronic Kidney Disease, Hx of Tobacco use, Anemia, Hypertension, a history of Myocardial Infarction, a history of having a G-Tube, a history of a Cerebral Aneurysm, Stroke, a history of having a Tracheostomy, Anxiety, Depression, Insomnia, and Dysphagia. The resident's quarterly Minimum Data Set (MDS) dated 11/08/2013 indicated the resident to be severely cognitively impaired and having a Basic Interview for Mental Status (BIMS) of 3. The MDS also indicated the resident needed extensive to total assistance of 1-2 persons for Activities of Daily Living (ADLs). The resident's Care Plan (CP) dated 03/11/2013 indicated the resident as having - Activity deficit and physical limitations due to medical status of a history of stroke, Tracheostomy, Feeding tube, Hypertension, Chronic Kidney Disease and wound care. The CP goals indicated the facility would - Involve resident in activities that he will respond to. The CP also documented the interventions for the resident to be - Do individual 1:1 activities with the resident 1 - 2 times a week. A review of the resident ' s activity plan of care progress note dated 11/04/2013 indicated the resident was disoriented (oriented to self only), non-verbal, and activity interests were music, pets, TV, and religion. The progress note also indicated the resident will be involved in activities he can respond to. Resident needs assistance, stimulation music, radio, and TV. Activities will do 1:1 in room activities 1 - 2 x a week. An initial observation was made of resident #73 on 11/17/2013 at 12:47 p.m. during the facility tour. The resident was in his room lying in his bed. There was no activity observed being	F 248		

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F 248	Continued From page 8 conducted with the resident. Three additional observations were conducted between 1:30 p.m. and 4:30 p.m. The resident was not observed out of bed or to have any in room 1:1 activities provided during the observations. On 11/18/2013 multiple observations of resident #73 were made at 8:38 a.m.; 9:43 a.m.; 11:12 a.m.; and 2:59 p.m. No activities were observed (1:1 activity, exercises, music therapy etc.) being conducted with the resident who was moved from room 128 to room 121 and remained in his room in bed. On 11/19/2013 multiple observations of the resident were made at 7:33 a.m.; 8:59 a.m.; 10:23 a.m.; 12:22 p.m.; 1:50 p.m. and 3:25 p.m. No activities were observed (1:1 activity, exercises or music therapy) being conducted with the resident who remained in his room in bed. On 11/20/2013 multiple observations were made of the resident at 9:02 a.m.; 10:12 a.m.; 11:17 a.m. No activities were observed being conducted with the resident who remained in her room either in bed or in her wheelchair at the bed side. An interview was conducted with the Activities Director on 11/20/2013 at 11:30 a.m. concerning activities conducted with facility residents. The activities director indicated she had monthly and daily activity logs to indicate which residents received or attended activities and the Assistant Activities Volunteer had 1:1 activity logs indicating which residents received 1:1 and in room activities. The activities director indicated that she had been without an activities assistant since the end of October but just hired an activities assistant yesterday (11/19/2013) and hoped the logs the Assistant Activities Volunteer had been keeping were current and had been updated. The Activity Director indicated there was no	F 248		

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F 248	Continued From page 9 monthly activity log for November 2013 showing what activities the residents participated in. The Activities Director provided daily activity logs for November 2013 which indicated by checks, asterisks, or other marks which residents attended or received in or out of room activities. A review of the November daily resident activity log sheets from 11/06/2013 through 11/19/2013 was conducted. There were no logs for November 1st, 4th, or 5th. The Activities Director indicated she did not know where the sheets for those dates were or if they had any. The reviewed daily resident activity logs for November revealed there were no entries or documentation to indicate resident #73 received any activities during the month of November 2013 (last 20 days). The Activities Director again indicated there was no monthly activities log for November 2013 and she could not find any daily resident activity logs during November which indicated resident #73 received any form of activity. The Activities director indicated there were no other monthly, daily or 1:1 activity sheets for November 2013 kept in any other location except the Activities Assistant Volunteer may have some on her desk or in her notebook. An interview with the Assistant Activities Volunteer was conducted on 11/20/2013 at 12:05 p.m. The assistant volunteer indicated she filled out and was responsible for documenting the resident daily activity log sheets and the daily 1:1 activity log sheets which she kept at her desk in her notebook. The Assistant Activities Volunteer looked on her desk and in her notebook then indicated she did not recall doing any 1:1 exercises, music or other type activity with resident # 73 during the month of November 2013. During the interview the Activities Director	F 248		

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F 248	Continued From page 10 asked the Assistant Activities Volunteer if she had logged any activities with resident #73 during the first 3 weeks of November. The Assistant Activities Volunteer indicated she had talked to the resident several times in the halls but did not spend at least 15 minutes with the resident at any time as she had been instructed that talking to the resident in the hall did not count as an activity and not spending at least 15 minutes with the resident doing an activity did not count and could not be logged. The Assistant Activities Volunteer indicated she could not remember doing any 1:1 activities with resident #73. An observation was made of the Assistant Activities Volunteer reviewing her notebook and the documented 1:1 activity sheets and daily activity sheets for November a second time. Resident #73's name was not listed on any of the 1:1 activity sheets (June through October 2013) as having any 1:1 activities conducted with her. The Assistant Activities Volunteer indicated there were no documented 1:1 activities for resident #73 during the months of June through October 2013 and there was no 1:1 activity sheet for November 2013 as she had not done one for November 2013. The most recent 1:1 resident activity sheet found by the Assistant Activity Volunteer and observed/reviewed was dated 10/23/2013. The Assistant Activity Volunteer did find the 3 previously missing daily resident activity log sheets dated November 1st, 4th, and 5th. A review of the 3 resident daily activity log sheets revealed resident #73 was not documented as receiving any activity on these days. The Assistant Activities Volunteer indicated the residents didn't have any activities thus far in November as far as she knew. On 11/20/2013 at 12:13 p.m. a second interview	F 248		

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F 248	Continued From page 11 was conducted with the Activities Director. The Activities Director indicated she had no other documentation to show resident #20 had received any activities during the first three weeks of November 29013.	F 248		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews the facility failed to maintain an adequate amount of light through fixtures in 2 of 3 resident community bathrooms. The findings include: On 11/17/2013 at 12:25 p.m. a tour of the facility was conducted. During the tour the women's community shower room on main hall (SNF unit) was observed to have 1 of 2 light bulbs burned out in shower stall #1, 1 of 2 light bulbs burned out in shower stall #2, 1 light bulb missing and 2 light bulbs burned out over the sink and mirror (no working lights over the skin and mirror). During the same tour an observation was made at 1:10 p.m. of the community co-ed shower room on the long hall (ICF unit). Shower stalls #1 and #2 were observed to have both lights not working/burned out. An interview was conducted with NA #1 on 11/17/2013 at 1:20 p.m. The NA indicated the lights over the showers in both community	F 256	**F 256** 1. All missing or burned out light bulbs were replaced with working light bulbs in both shower rooms. 2. The Executive Director has re educated the Maintenance Director concerning the need to make a daily round of the facility to identify any burned out or missing light bulbs. All facility light fixtures were inspected to identify any burned out or missing bulbs. These were immediately replaced with working bulbs. Facility staff was re educated by the Maintenance Director concerning the process for maintenance repairs. This re education included the location of the repair logs and that anything that is not working needs to be listed on the log for repair.	12/20/13

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F 256	Continued From page 12 shower rooms and over the sink in the community women's shower room had not worked in a long time. The NA indicated it was difficult to shower and groom residents with the reduced lighting. The NA indicated she was unaware if a work order request had been submitted to get the lights in ether community shower room replaced/repaired. On 11/17/2013 at 4:00 p.m. a second observation was made of both community bathrooms found to have burned out/non-operational lights. During the observation all lights previously noted to be burned out or non-operational were found to be still burned out and/or non-operational. On 11/18/2013 at 8:18 a.m. a third observation was made of the community women ' s shower room on the main SNF unit hall. Over the sink 1 light bulb was found to still be missing and the other 2 bulbs were observed to be non-operational or burned out. An observation of the shower stalls revealed 1 light over each shower was still burned out and/or non-operational. At 8:22 a.m. a third observation of the co-ed community shower room on ICF hall was conducted. The two lights over each of the shower stall were observed to still be burned out and/or non-operational. On 11/19/2013 at 8:18 a.m. a fourth observation was made of the community women ' s shower room on the main SNF unit hall. Over the sink 1 light bulb was found to still be missing and the other 2 bulbs were observed to be non-operational or burned out and the two shower stalls revealed 1 light over each shower stall was still burned out and/or non-operational.	F 256	**F 256 (cont.)** 3. The Executive Director will make rounds of the facility to identify any light bulb that is out and had not been identified and placed on the log. He will document these rounds on the Adequate Lighting monitoring tool daily x 5 days, 3 x a week x 4 weeks, weekly x 4 weeks, and then monthly x 10 months. 4. The Executive Director will report the findings of the monitoring to the Quality Assessment and Assurance committee monthly for review and recommendations for the duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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F 256	Continued From page 13 On 11/20/2013 at 6:20 p.m. a fifth observation was made of the community women ' s shower room on the main SNF unit hall. Over the sink 1 light bulb was found to still be missing and the other 2 bulbs were observed to be non-operational or burned out. The two shower stalls were observed to have 1 light over each shower stall still burned out and/or non-operational. On 11/21/2013 at 1:45 p.m. an interview was conducted with the facility's Maintenance Director and Maintenance Assistant. The Maintenance Director and Assistant described the maintenance repair procedures as: All staff receive training during their orientation and hire process. They are instructed during the maintenance class how to out a Maintenance Repair Log entry on the forms located on the clipboard at each nurse's station. Both nursing stations are checked at random daily by both the director and assistant for new entries on the log sheets. The new work requests found on the log sheets are then reviewed and prioritized by the assistant for repair. Work that can be or needs to be accomplished immediately will be conducted that way and when accomplished the work request log entry is signed off as completed. If parts for a repair are not on hand the repair work will be deferred (awaiting parts). The Maintenance Director indicated if parts are not on hand (out of stock) an order through the company's DSSI provider would be made and they would in turn send a quote (parts cost) back to the facility. Once the quote is received and approved by the facility ' s corporate office the order is then finalized and the parts are ordered from the DSSI or 3rd party vendors. When the part(s) come in the item(s) are then repaired and signed off on	F 256		

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F 256	Continued From page 14	F 256		

the log sheets.

A review of all of the current work orders for the facility was reviewed with the Maintenance Director and the Assistant. There were no outstanding/uncompleted work orders noted on the logs at either nurse's station. All work order requests reviewed were signed off as being completed. The maintenance Director and Assistant indicated there were no other uncompleted maintenance request logs kept at any other locations to indicate maintenance was needed.

On 11/21/2013 at 1:53 p.m. a sixth observation of the facility was made with the Maintenance Director and Assistant. An observation was made of the community women's shower room on main SNF hall. The missing light and two burned out lights over the sink and mirror were still found to be missing and burned out. One light bulb was observed to still be burned out/non-operational over shower stalls #1 and #2. During the observation of the community co-ed shower room on the ICF hall revealed the lights over both shower stalls were still not working. The facility's Maintenance Director indicated he was unaware of the lights not working in either community shower room, never received a work order request for the burned out/non-working/missing lights, and no verbal report had been given to him or his assistant indicating the lights did not work.

On 11/21/2013 at 2:09 p.m. and interview was conducted with NA #2 who was using the ICF hall's community co-ed shower room. The NA was asked about the facility's maintenance request procedures. The NA indicated she did not know she was supposed to fill out an entry in

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F 256	Continued From page 15 the Maintenance Repair Log when she found an item in the facility in need of repair or replacement. The NA could not state where the Maintenance Repair Log sheets where kept/available or how to fill them out. The NA was also unaware of who to contact when she found something broken or in need of repair.	F 256		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the Care Plan for 1 of 1 residents (Res. # 46) to include a change in diet texture for a resident who experienced	F 280	**F 280** 1. Resident #46 was monitored to assess if there is any ongoing changes related to the swallowing difficulty and expulsion of liquids. The meal card for Resident #46 was updated to reflect the latest physician's order for the diet to be Liberalized Renal Low Concentrated Sweets Diet/ Pureed. 2. All diets were reviewed by the Regional Director of Dietary immediately upon finding that this issue was found. There were no consistency issues that were discovered and any inconsistencies between physician orders and meal tickets were immediately clarified with the physician. The current licensed nursing staff has been re educated concerning the necessity of documenting the assessment of any resident with vomiting and difficulty swallowing on the SBAR form and the process of transcribing any change in a	12/20/13

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F 280	Continued From page 16 swallowing difficulties and expulsion of liquids. Findings included: Resident #46 was admitted to the facility on 12/10/10 with a diagnosis of Bacteremia, and re-admitted on 10/25/13 from the local hospital with a diagnosis Community-Acquired Pneumonia. Current cumulative diagnoses included Bacteremia, Diabetes Mellitus, Esophageal Reflux, End Stage Renal Disease and Epilepsy. Physician orders of 11/2/13 read: "Change diet to Pureed due to expulsion of liquids." Physician orders of 10/29/13 read: Liberalized Renal Low Concentrated Sweets Diet/Pureed. A 1200 cc /day fluid restriction was ordered on 10/29/13. Review of the Daily Skilled Nursing Notes from 11/05/13 - of 11/7/13 at 10:00 PM read: " Complained of difficulty tolerating dinner related to expulsion of liquids and difficulty completely swallowing food. " (Referring to the resident) "States "Feels like there is a lump there. Diet changed to pureed with relief obtained. States (referring to the resident) personal medical history includes Hiatal Hernia and has difficulty with food on occasion. " Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/07/13 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, had Active Diagnoses of End Stage Renal Disease, required a Mechanically Altered Therapeutic Diet, had a Swallowing Disorder with difficulty or pain swallowing, and Special Treatment included Dialysis. The Care Plan dated 11/01/13 read: Long term	F 280	**F 280 (cont.)** diet order. This includes writing a diet communication order slip and sending the original to the dietary department and the copy placed in the resident chart. 3. The Director of Clinical Service will review the 24 hr report during morning meeting and verify that the SBAR has been completed. The copy of the previous day's orders will be reviewed and any change in a diet order will have verification that the diet order communication form has been sent to the Dietary Director. This monitoring will be documented on the Change of Condition Documentation/Dietary Order Change Process monitoring tool every morning meeting for 7 morning meetings, 3x a week x3 weeks, weekly x 4 weeks, monthly x 10 months.	12-20-13

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F 280	Continued From page 17 memory deficit, vision impairment, and hearing impairment. Requires dialysis 3 times a week due to ESRD (End Stage Renal Disease). The Physician ' s 11/11/13 included a 1200 cc fluid restriction (840 ml dietary,120 ml Nursing).At risk for dehydration and hypoglycemia. The Care Plan of 11/11/13 was not updated to include the Pureed Diet orders of 11/7/13. Review of the Dietary Progress Notes of 11/11/13 authored by the Registered Dietitian read: "Diet texture downgraded to Pureed secondary to expulsion of liquids. Continue to monitor." Meal observation conducted 11/19/13 at 9:00 AM indicated the resident received a Liberalized Renal Diet Low Concentrated Sweets NAS Diet (not ordered) Mechanical Soft with Fluid restriction. The diet was not changed to Pureed as ordered on 11/7/13. Observations of the Breakfast meal on 11/20/13 at 8:45 AM indicated the resident received a Low Concentrated Sweets/No Added Salt Mechanical Soft diet with fluid restriction. The diet was not changed to pureed as ordered on 11/7/13. A staff interview was conducted on 11/20/13 at 9:10 AM with the Food Service Director (FSD). During the interview the FSD indicated not having received a Diet Communication Order slip for the Pureed Diet A staff interview with Nurse # 1 was conducted on 11/20/13 at 9:15 AM regarding how the telephone orders were communicated to Dietary. The Nurse indicated "We are responsible for getting it to Dietary/walking it over there."	F 280	**F 280 (cont.)** 4. The Director of Clinical Services will report the results of the monitoring to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC 12-20-13	12-20-13

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F 280	Continued From page 18 Interview with the Director of Nurses on 11/20/13 at 11:50 AM revealed the expectation was, "The Nurse should have filled out a(SBAR) (Change of Condition Form) and any Diet Change should be communicated to Dietary on the Diet Order and Communication Form. In this case the Pureed Diet change request should have been given to Dietary. I would have expected the Nurses to monitor after the incident of swallowing difficulty and expulsion of liquids. The Pureed Diet should have been on the Care Plan."	F 280	**F281** 1. Resident #16 is now receiving her synthroid medication according to physician order. 2. All resident MARs were compared to the physician orders to ensure that two matched and the MAR was reviewed for medications missed or documented as given incorrectly. Licensed nurses have been re educated concerning the execution of medication administration by following the MAR. 3. The Director of Clinical Services or Unit Manager will review the MAR for completion. Any medication that is not documented as given will be followed up with the nurse to identify if the medication was given. The monitoring will be documented on the Medication Administration monitoring form daily x 7 days, 5days a week for one week, 3 days a week for 2 weeks, weekly x 4 weeks, and then	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, interview with the consultant pharmacist and interview with staff the facility failed to administer an increased dose of Synthroid for 7 days. This was evident in 1 of 6 residents in the sample reviewed for unnecessary medications. Resident #16 Finding included: Resident #16 has numerous diagnoses which included hypothyroidism. Review of the July 2013 monthly physician orders revealed orders for Synthroid 88 microgram (mcg) by mouth once a day. Synthroid (levothyroxine) is a replacement drug for a hormone normally produced by the thyroid gland to regulate the body's energy and metabolism.	F 281		12/20/13

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F 281	Continued From page 19 Review of the medical record revealed on 7/16/2013 a thyroid stimulating hormone (TSH) laboratory test was performed. Review of the results revealed a level of 41.51 MIU/L. The reference range was 0.40-5.50 MIU/L. Record review revealed on 7/18/13 a physician order was written to increase the Synthroid dose to 100 mcg daily. Review of the Medication Administration Record (MAR) revealed the increase dose of Synthroid to 100 mcg was transcribed onto the MAR and the previous dose of Synthroid 88 mcg was discontinued. Interview on 11/22/13 at 9:30 AM via the phone with the consultant pharmacist revealed the pharmacy dispensed Synthroid 100 mcg on 7/19/13 during the daily delivery. Review of the MAR revealed the resident had not received the increased dose until 7/25/13. Nurse#8 signed that she was the nurse receiving the order for the increase dose of Synthroid. On 11/19/13 at 2:30 PM an interview via the phone with Nurse#8 revealed she transcribed on 7/18/13 the order to increase the Synthroid onto the MAR and it was never given. Nurse#8 indicated she initiated a medication error report and submitted to the director of nurses. Additionally, Nurse#8 indicated there was a question about the time that the medication was to be administered and the administration time was changed from 9 AM to 6 AM. Interview on 11/19/13 at 11:04 AM with Nurse#5 (who worked 7/22/13, 7/23/13 and 7/24/13)	F 281	**F 281 (cont.)** monthly at turnover of MAR from one month to the next. 4. The Director of Clinical Services will report the results of the monitoring to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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F 281	Continued From page 20 revealed she was assigned that day to give medications and did not know why the Synthroid was not administered. Interview on 11/19/13 at 11:11 AM with Nurse#3 (who worked 7/20/13 and 7/21/13) revealed " I do not have an answer, I do not know " why the increase of Synthroid 100 mcg was not administered. Nurse#7 who worked 7/19/13 was not available at the time of survey. Continued record review revealed on 7/24/13 a nurse practitioner ' s telephone order was obtained to restart Synthroid 100 mcg in the early AM and recheck the TSH level in appropriately 6 weeks. On 10/8/13 a repeat TSH was done and the result was 56.09 MIU/L. The Synthroid was increased to 125 mcg.	F 281	**F 314** 1. Resident #16 was assessed with a stage IV wound and current treatment orders were being followed. 2. Current residents have had full body skin assessments to identify any undocumented change in skin condition. No unidentified skin issues were found. The skin sweeps will be done weekly according to facility policy as assigned by the Director of Clinical Services. The Nursing staff were re-educated concerning the identification of new skin issues, the communication to the Charge Nurse of the resident involved, the documentation of the location and stage of the skin tissue by a RN, notification made to the resident's Responsible Party and the Attending Physician by the Charge Nurse, the receipt of orders for treatment of the new skin issue and the communication to all nursing staff of the resident's condition and treatment orders. All new skin issues will be written on the 24 hour nursing report.	
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, interviews with staff and record reviews the facility failed to conduct	F 314		12/20/13

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F 314	Continued From page 21 ongoing assessments of a facility acquired stage 1 pressure sore until the pressure sore progressed to an advanced stage 4 pressure sore. This was evident in 1 of 3 residents reviewed for pressure sores. Resident#16 Resident #16 had cumulative diagnoses which included bilateral fractured ankles with open reduction and internal fixation due to a fall Review of the discharge summary from the hospital (undated) with a discharge date of 7/2/13 revealed the resident was on Hospice for co-morbidities. Review of the admission/readmission data collection form dated 7/9/13 revealed the resident skin was intact for pressure sores. A skin risk assessment was done using the Braden scale which indicated a score of 13. A score of 13-14 indicated the resident was at moderate risk for pressure sore development. Review of the Minimum Data Set (MDS) assessment dated 7/14/13 revealed the resident was alert and oriented at the time of admission but required extensive assistance for staff for all activities of daily living especially for turning and repositioning, Review of the SBAR (Situation, Background, Assessment or Appearance and Request) communication and progress form dated 9/17/13 revealed the resident coccyx area was red with non-blanchable area. Crème applied. There was no indication of the type of cream applied. The therapy department was made aware to order a different mattress.	F 314	**F314 (cont.)** 3. The Director of Clinical Services will review the 24 hour nursing report and all copies of the new orders in the morning Department Head meeting. The full body audits will be reviewed daily to verify that the previous day's assignment was completed and to verify that any new skin issue was identified and handled according to the education. This monitoring will be documented on the Pressure Sore Prevention tool and reviewed in the morning Department Head meeting each day for 7 days; 3 days a week for 4 weeks; 1 times a week for 8 weeks and then once a month for 9 months. 4. The Director of Clinical Services will report findings of the monitoring tool to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC 12-20-13	12-20-13

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F 314	Continued From page 22 Review of the medical record revealed there was no follow-up on the status of the resident ' s reddened coccyx. Review of the SBAR form dated 10/7/13 revealed a pressure sore located on the sacrum appeared to be a Stage 4. A stage 4 pressure sore is very deep, reaching into muscle and bone and causing extensive damage. Damage to deeper tissues, tendons, and joints may occur. The sore was noted to be " very necrotic [dead tissue] " that measured 10 centimeters (CM) by 6 CM, with an offensive brown tinged drainage. The physician was notified and ordered Santyl ointment with wet to moist dressing every day. Interview on 11/19/13 at 4:30 PM with (nursing assistant) NA#10 assigned to resident but revealed she did not usually take care of the resident. I know she needs to be fed. I do not know anything about her sore. Interview on 11/19/13 at 4:45 PM with NA #11revealed this was the resident ' s second admission to the facility she was more mobile when she was first admitted. I did notice the redness on her buttocks and we used barrier cream. NA #11 indicated she never saw the sore until after it was debrided. Sometimes the redness would go away. I never notice her skin to breakdown. NA#11 did not comment as to whether or not she communicated with the nurse about the status of the resident ' s skin. Interview on 11/19/13 at 4:55 PM with NA #12 revealed resident required total care. The resident was turned every 2 hours. She needed to be fed. I notice her coccyx was red so we use protective ointment. The redness never went	F 314		

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F 314	Continued From page 23 away on her buttocks. NA #12 did not comment as to whether or not she communicated with the nurse about the status of the resident ' s skin. Interview on 11/19/13 at 11:50 AM with the treatment nurse revealed no one ever reported to her that the resident had a reddened area on the coccyx. The treatment nurse indicated she did not know that she had a reddened area until 10/9/13 when the nurse reported to her a stage 4 sacral pressure sore. Observation on 11/20/13 at 10:30 AM of the wound care performed by the treatment nurse with the assistance of Nurse #3 was done. The area of the wound was located in the sacral and coccyx area. The treatment nurse acknowledged the pressure sore was located in the sacral and coccyx region. Interview on 11/20/13 on 1:25 PM with the attending physician revealed the redden pressure sore on the coccyx was probably the same area that developed to a stage 4 on the sacrum.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. This REQUIREMENT is not met as evidenced	F 315		12/20/13

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F 315	Continued From page 24 by: Based on observations, record review and interview the facility failed to anchor an indwelling urinary catheter to avoid excessive tension or accidentally displacement. This was evident in 1 of 1 resident in the survey sample with an indwelling urinary catheter. Resident #99. The facility failed to use a cleansing agent when an episode of bowel and bladder incontinence occurred. This was evident in 1 of 1 resident in the sample reviewed for incontinence care. Resident #16 1. Resident #99 was readmitted to the facility after a 6/19/13 hospitalization with cumulative diagnoses which included coronary artery disease, history of urinary tract infection, and stage 4 sacral pressure sore. Review of the quarterly Minimum data set (MDS) assessment dated 9/6/13 revealed the resident required extensive assistance with the activities of daily living. The resident was alert and oriented. Review of the careplan dated 6/13/13 and revised 9/10/13revealed a problem onset for the use of an indwelling catheter secondary to a pressure sore. One of the approaches included to secure catheter to the leg to avoid tension on the urinary meatus. Observation of care on 11/20/13 at 9:37 AM performed by nursing assistant (NA) NA #3 revealed the urinary indwelling catheter was connected to a drainage bag was not anchored. Interview on 11/20/13 at 11:45 AM with NA #3 revealed she was not aware that the resident	F 315	**F 315** 1. Resident #99 had a leg strap placed to hold his catheter in place immediately upon notification to the Director of Clinical Services. NA #6 was re educated that a cleansing agent is to be used while performing pericare as soon as the issue came to her attention. 2. Nursing staff has been re educated that all residents with catheters must have an anchor on the thigh to avoid tension on the urinary meatus and that pericare will be performed using a cleansing agent. 3. The nursing staff is responsible for the care of the catheter. The Director of Clinical Services, Unit Manager, or staff nurse will observe each nursing assistant performing pericare to ensure that a cleansing agent is used and that the education was effective. This will be	12-20-13

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F 315	Continued From page 25 needed a strap or something to secure the catheter. It has never been (referring to the urinary catheter) secured since I have worked with him. " I do not know what we would use for anchoring. " Interview on 11/20/13 at 9:45 AM with Resident #99 revealed he had a urinary tract infection, receiving antibiotic and burns when he urinates. Resident#99 revealed he never had a strap or anything to anchor the catheter. The resident indicated " I could use one because it would stop pulling when I move. " Observation on 11/20/13 at 10:12 AM with treatment nurse indicated the urinary catheter was dangling and not anchored. The treatment nurse repositioned the catheter and did not anchor the catheter. The resident requested a catheter strap. The treatment nurse acknowledged his request and indicated she would return with a strap to anchor the catheter. Interview on 11/20/13 at 10:25 AM with Nurse #3 revealed she was responsible for the catheter care since it is written on the treatment record. By 11 AM Nurse #3 indicated any nursing staff could do catheter care. On 11/20/13 at 10:50 AM Resident #99 indicated that his penis was still burning, had no secure anchoring of the catheter and the catheter was still dangling. On 11/20/13 Resident #99 activated the call light at 10:52 AM. Nurse#3 responded. The catheter was still not anchored. Interview on 11/20/13 at 11:50 AM with NA#6	F 315	**F 315 (cont.)** documented on a list of nursing assistants employed by the facility. The Director of Clinical Services, Unit Manager, or staff nurse will observe residents with catheters to ensure that the leg strap is in place. These observations will be documented on the Catheter Anchor Placement monitoring tool daily, all three shifts x 7 days; random shifts x 5 days a week x 3 weeks, random shifts 3x a week x 4 weeks, weekly x 4 weeks, then monthly x 9 months. 4. The Director of Clinical Services will report the findings of the observations to the next Quality Assessment and Assurance committee and will report the findings of the monitoring of the catheter anchoring regularly thru the monitoring period for review and recommendations for the	12-20-13

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F 315	Continued From page 26 revealed she did not know anything about the anchoring and stabilization of the catheter. NA #6 indicated the nurses take care of the catheter and the NA wash around the penis. Observation and interview on 11/20/13 at 12 noon with Nurse #3 revealed the resident's catheter was dangling and did not have a method to anchor the catheter. Nurse #3 indicated that we usually only use a catheter strap when the resident has a leg bag. Interview on 11/20/13 at 12:45 PM with the director of nurses revealed the resident had a strap applied and her expectation was to have a clamp or strap used to be used to anchor the catheter. 2. Resident #16 had cumulative diagnoses which included bilateral fractured ankles with open reduction and internal fixation due to a fall and a stage 4 pressure sore. A stage 4 pressure sore is very deep, reaching into muscle and bone and causing extensive damage. Damage to deeper tissues, tendons, and joints may occur. Review of the admission Minimum Data Set (MDS) assessment dated 7/14/13 revealed the resident was alert and oriented at the time of admission and totally dependent on staff for bathing. The MDS coded the resident as incontinent of bowel and bladder. Review of the careplan dated 7/22/13 revealed a problem of self care deficit due to decreased mobility and confusion. One of the interventions included to assist/provide total care as needed with bathing. An updated care plan on 10/7/13 revealed a problem with an actual pressure sore	F 315	**F 315 (cont.)** duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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F 315	Continued From page 27 and at risk for the development of the pressure ulcer due to incontinence of bowel and bladder. Review of the medical record revealed Resident #16 was treated for a urinary tract infection with Rocephin (an antibiotic) on 10/5/13 through 10/6/13. Observation on 11/20/13 at 9:30 AM of the incontinence care for Resident # 16 performed by NA #6 with the assistance of the wound nurse revealed the resident experienced an episode of incontinence of urine and stool. NA #6 wet three cloth wash cloths at the sink with water and no soap or cleaning agent. The resident was repositioned on her back. One of the wet washcloths were used to clean the resident groin and between her labia. A second wash cloth was used to clean the stool off the rectum. There were no cleansing agents used on the skin to remove the urine and stool off of the resident ' s skin. Interview with NA #6 immediately after the observation revealed she just used warm water because the resident was scheduled for a bath and had not completed the resident ' s bath. On 11/20/13 at 11:30 am NA #6 indicated that the resident had not been bathed yet. On 11/20/13 at 11:35 am NA #6 indicated she would bath the resident now but the resident had visitors. By 12:30 pm the resident had not received a bath. Interview on 11/20/13 at 12:45 pm with the director of nurses revealed her expectation was to have a cleaning agent be used to clean the resident and not just a cloth wet with water unless the resident was to be immediately showered.	F 315		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with staff and an interview with the attending physician the facility staff failed to transcribe the order to discontinue Seroquel which resulted in continued administration. The facility restarted Seroquel without a medical justification. This was evident in 1 of 6 residents reviewed for unnecessary drugs: Resident #16	F 329	**F 329** 1. The medications for Resident #16 were reviewed with the physician orders to ensure that all orders had been properly transcribed. All resident MARs were compared with their physician orders during the monthly change over and all MAR are correct. 2. All current resident MARs were reviewed to ensure that the physician orders and the transcribed order on the MAR matched. The licensed nursing staff has been re educated concerning the transcribing of physician orders. This re education includes that the nurses working third shift will check every chart, every night and sign their initials to each new order that they have verified proper transcription of the order.	12/20/13

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F 329	Continued From page 29 Findings included: Resident #16 was admitted to the facility with cumulative diagnoses which included dementia with behaviors. Review of the October 2013 physician orders revealed orders that included Seroquel 12.5 milligrams (mg) in the morning by mouth and Seroquel 50 mg by mouth at bedtime. Seroquel is a short-acting atypical antipsychotic drug. Review of the physician order sheet revealed a written telephone order by Nurse #2 dated 10/24/13 from the physician to discontinue the drug Seroquel. Interview on 11/21/13 at 2:05 PM with Nurse #2 revealed the family requested the physician to discontinue the Seroquel. Review of the MAR revealed from 10/25/13 through 10/31/13 Resident#16 continued to be administered Seroquel 12.5 mg in the AM. There were no written notations on the MAR that indicated the 10/24/13 order for the discontinuation of the Seroquel. Continued review of the MAR revealed a yellow colored highlight was noted over the evening dose of Seroquel 50 mg which indicated not to administer the drug. Interview on 11/21/13 at 2:45 PM with Nurse #8, Nurse #2 and Nurse#4 was held. Nurse #2 indicated that there were pages of several phone calls from the attending physician so she answered the phone and took the telephone order since she was a nurse. Nurse #2 indicated she did not transcribe the order onto the Medication administration Record (MAR). Nurse #8 indicated that the telephone order had not	F 329	**F 329 (cont.)** 3. The Director of Clinical Services or Unit Manger will check the charts for signatures that the night shift had checked the chart the previous night. The charts will be checked according to assignment. This check will be documented on the Transcription Verification monitoring tool daily x 7 days, 5 days a week x 3 weeks, weekly x 8 weeks, and then monthly during change over x 9 months. 4. The Director of Clinical Services will report the findings of the monitoring to the Quality Assessment and Assurance committee for review and recommendation for the duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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F 329	Continued From page 30 been signed by Nurse #2 and she requested Nurse #4 to take the order to Nurse #2 to be completed. Further interview with Nurse #8 revealed she did not transcribe the order nor tell the oncoming nurse that the Seroquel had been discontinued. Each nurse indicated that did not know who used a yellow colored highlight to indicate the PM dose was discontinued. Interview on 11/19/13 at 9:44 AM with Nurse #9 revealed the nurse who wrote the verbal or telephone order and signs the " signature of nurse receiving order " column on the order sheet should transcribed the new order onto the MAR and fax the new order to pharmacy. Interview on 11/21/13 at approximately 8:45 AM via the phone with Nurse #3 (who worked 10/2713, 10/28/13, 10/30/13, 10/31/13 and 11/1/13) revealed she had too may residents and she could not remember why she gave the medications when their was an order to be discontinued. Interview on 11/21/13 at 1:50 PM with Nurse #5 (who worked the day shift on 11/25/13) and Nurse #14 (who worked the day shift on 11/26/13) revealed the order was not yellowed out with a highlight or written as discontinued so they administered the medication. Nurse #15 who worked 10/24/13 and Nurse #16 who worked 10/29/13 were not available for interview. Review of the November 2013 monthly computerized physician orders indicated Nurse#9 reviewed the orders on 10/27/13. Seroquel 12.5 mg AM dose was not discontinued. There was a	F 329		

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F 329	Continued From page 31 handwritten justification of dementia with behaviors added in the column next to the drug. There was a computerized entry of Seroquel 50 mg at bedtime. A note was then written by Nurse#9 which stated D/C (discontinued), error and rewritten. Below this notation Seroquel 25 mg take 2 tablets (50 mg) by mouth at bedtime was rewritten. Review of the November 2013 MAR revealed Seroquel12.5 mg was administered on 11/1/13 at 9 AM and Seroquel 25 mf (2) tablets at 10 PM was given on 11/2/13. Continued review of the physician orders revealed a telephone order on 11/6/13 for Seroquel 25 mg at night for 2 nights then discontinue. Review of the medical record revealed no behaviors or justification to restart the Seroquel. Interview on 11/20/13 on 1:25 PM with the attending physician indicated he probably did not realize he had previously discontinued the drug.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure a medication error rate of less than 5% as evidenced by 1 omission and 1 wrong dose out of	F 332		12/20/13

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F 332	Continued From page 32 29 opportunities resulting in a medication error rate of 6.896% for resident # 23. The findings include: 1a) Resident #23 was admitted to the facility on 12/15/2011 and had diagnoses which included Osteoporosis. The resident had a physician's order dated 08/13/2012 for Calcium 600mg to take 1 tablet by mouth twice daily at 8:00 a.m. and 8:00 p.m. for Osteoporosis. On 11/19/2013 at 7:58 a.m. a medication pass observation was conducted with nurse #5 on the SNF nursing unit's north hall. While drawing up the resident's medications the nurse indicated she did not have resident #23's physician ordered Calcium 600mg tablets on the medication cart. The nurse then locked the cart and went to the SNF unit's medication room to find the medications. Upon the nurse ' s return to the medication cart the nurse began looking through her medication cart for the appropriate Calcium tablets. While looking in the bottom drawer the nurse indicated she had found the correct Calcium tablets and placed one of the tablets into the resident's soufflé cup with the resident's other medications. A review of the Calcium tablet bottle was made immediately after the nurse withdrew the tablet for the resident. The container documented the Calcium tablets were 500mg tablets. The nurse was observed to administer the drawn up medications to resident #23 at 8:45 a.m. while the resident ate her breakfast meal. The nurse had already signed off the Calcium 600mg and other 8:00 a.m. medications as administered. A medication reconciliation review of resident #23's medical chart was conducted. During the	F 332	**F 332** 1. For Resident #23, Mylanta Double Strength was obtained. The MD was made aware of the omission and ordered that the medication was to wait until the next scheduled dose. The MD changed the Calcium to 500mg instead of 600mg for Resident #23. 2. The nursing staff was re educated concerning the right resident, right medication, right dose, right route, and at the right time. 3. The Director of Clinical Services or RN Designee will observe med pass for 1 nurse per day until all nurses are observed, then 1 nurse per week x 12 weeks, then 1 nurse per every 2 weeks x 12 weeks. This monitoring will be documented on the Medication Pass Observation tool.	12-20-13

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F 332	Continued From page 33 review it was revealed the physician ' s order for the Calcium was for 600mg tablets and not the 500mg tablet observed to be administered by the nurse. On 11/19/2013 at 11:43 a.m. an interview was conducted with nurse #5. The nurse indicated she had completed her 8:00 a.m. medication pass. The nurse was asked to review the Calcium bottle which was used to obtain the Calcium tablet for resident #23's 8:00 a.m. dose. Nurse #5 reviewed the Calcium bottle (container) she used to acquire the tablet for resident #23. The white bottle indicated on the front label the Calcium tablets were 500mg tablets. The nurse indicated she had given the wrong dose of Calcium to resident # 23 On 11/21/2013 at 8:41 a.m. an interview was conducted with the facility's Director of Nursing (DON). The DON indicated her expectation was that all nurses administering medications would use the 5 R's (right resident, right medication, right dose, right route, and at the right time) to negate errors. The DON indicated she expected, and the nurse's knew they could get help from their unit manager, the treatment nurse, or the DON when there is a problem or issue administering medications. 1b) Resident #23 was admitted to the facility on 12/15/2011 and had diagnoses which included GERD (Acid Reflux). The resident had a physician's order dated 06/27/2013 for Almacone - 2 - 400-400-40 (Mylanta Double Strength Suspension) to take 15 milliliters by mouth before each meal.	F 332	**F 332 (cont.)** 4. The Director of Clinical Services will report the findings of the monitoring to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL ST WALNUT COVE, NC 27052

(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 332	Continued From page 34 On 11/19/2013 at 7:58 a.m. a medication pass observation was conducted with nurse #5 on the SNF nursing unit's north hall. While drawing up the resident's medications the nurse indicated she did not have resident #23's physician ordered Mylanta Double Strength Suspension on the medication cart. The nurse then locked the cart and went to the SNF unit's medication room to find the medication. Upon the nurse's return to the medication cart the nurse indicated the facility was out of the Mylanta Double Strength Suspension The nurse was observed to administer the drawn up medications to resident #23 at 8:45 a.m. while the resident ate her breakfast meal. Upon the nurse's return to her medication cart she circled her initials for the Mylanta Double Strength Suspension she had previously placed on the resident's Medication Administration Record (MAR) prior to drawing up the medications and indicated on the back of the resident's MAR the Mylanta Double Strength Suspension was " Not available. " A medication reconciliation review of resident #23's medical chart was conducted. During the review it was revealed the Mylanta Double Strength Suspension was ordered to be administered to the resident before each meal to prevent GERD (Acid Reflux). On 11/19/2013 at 11:43 a.m. an interview was conducted with nurse #5. The nurse indicated she had completed her 8:00 a.m. medication pass. The nurse indicated she had not administered resident #23's Mylanta Double Strength Suspension as there was none in the facility to administer. The nurse was asked what	F 332		

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F 332	Continued From page 35 she had administered before breakfast to resident #23 for the resident's GERD. The nurse indicated she did not administer the Mylanta Double Strength Suspension to resident #23 before or after the breakfast meal or any other medication for the resident's GERD. On 11/21/2013 at 8:41 a.m. an interview was conducted with the facility's Director of Nursing (DON). The DON indicated her expectation was that all nurses administering medications would use the 5 R's (right resident, right medication, right dose, right route, and at the right time) to negate errors. The DON indicated she expected, and the nurse's knew they could get help from their unit manager, the treatment nurse, or the DON when there is a problem or issue administering medications.	F 332		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334		12/20/13

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F 334	Continued From page 36 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5	F 334	**F 334** 1. Resident #11 was immediately given her influenza vaccine 2. A full audit was completed on current residents to ensure that no other vaccine was missed. All other residents had received their vaccinations according to the consent signed. The Unit Manager assigned to the process of influenza and pneumonia administration was re educated by the Director of Clinical Services. 3. The Director of Clinical Services will audit the charts of new admissions during morning meeting and determine the consent status of the influenza and pneumonia. Any incomplete consent or vaccination not administered once the consent is signed will be corrected that day. This will be a permanent practice.	12-20-13

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F 334	Continued From page 37 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview with staff and record review the facility failed to administer the influenza vaccine once the consent was obtained for 1 of 5 residents in the sample reviewed for influenza and pneumonia immunizations. Resident # 11 Findings included: Review of the consent form and information form for the influenza vaccination revealed a signed consent by the responsibility party on 8/19/13 for Resident #11 to receive the flu vaccination. Review of the vaccination records revealed Resident#11 has not been offered or given the influenza vaccine as of 11/21/13. Interview on 11/21/13 at 4:10 pm with Nurse#11 revealed Nurse#10 started the immunization for the flu. Nurse #11 indicated Nurse #10 went on leave from the facility on 10/24/13 and the responsibility was forwarded to her. Nurse #11 indicated when she assumed responsibility for the vaccination she was provided a black binder of residents who needed vaccines and Resident#11 ' s consent or name was not in the black book. After the interview Nurse#11 returned and provided information that the consent was located in a blue binder and Resident# 11 would be administered the flu shot.	F 334	**F 334 (cont.)** The documentation of the practice will be on the Influenza and Pneumonia monitoring tool daily x 7 days, 5 days a week x 3 weeks, weekly x 4 weeks and then monthly x 10 months. 4. The Director of Clinical Services will report the findings of the monitoring to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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F 431 SS=E	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 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 observations and interviews with staff	F 431	**F 431** 1. All expired medications were removed from the SNF medication storage room; the SNF unit's south hall wound care treatment cart, ICF unit's short hall medication cart, ICF unit's long hall medication cart, and the ICF unit's wound care treatment cart. 2. All medication carts, treatment carts, and medication storage rooms have been inspected and all expired medications have been removed. Each room and cart will be checked using the Expired Medications monitoring tool to document that there are no expired medications present. The Pharmacy will be auditing the medication carts per their schedule. 3. The Director of Clinical Services or designee will check each room and cart will be checked using the Expired Medications monitoring tool to document that there are no	12/20/13

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F 431	Continued From page 39 the facility failed to remove and/or properly dispose of expired medications found to be available for use and comingled with unexpired medications in 1 of 2 medication rooms, 2 of 4 medication carts, and 2 of 3 wound care treatment carts. The findings include: On 11/19/2013 at 5:10 p.m. an observation was made of the SNF unit's medication storage room with nurse # 6. During the observation of the medication room the following expired medications were observed: In a gray plastic storage bin under the left side of the counter cabinet area comingled with unexpired medications and IV supplies: 5 - 1000 ml bags of premixed IV solution (NS with Viaflex). The attached preprinted pharmacy labels indicated the IV solution was premixed by Omnicare of Hickory and had an expiration date of 03/03/2013. The IV solution was dispensed for a resident who had been discharged from the facility. In the medication room's refrigerator: 3 - 250ml bags of premixed IV solution (NS with Vancomycine 1250mg). The attached preprinted pharmacy labels indicated the IV solution was premixed by Omnicare of Hickory and had an expiration date of 10/25/2013. The IV solution was dispensed for a resident who had been discharged from the facility. In the SNF unit's south hall wound care treatment cart's bottom drawer (stored in the medication room): 1 - Half used bottle of Triadine (Providine Iodine) antiseptic germicidal Lot # 0D28 expired 04/2013	F 431	**F 431 (cont.)** expired medications present daily for 7 days, 5 days a week x 3 weeks, weekly x 4 weeks and then monthly x 10 months. The Director of Clinical Services will receive reports from the pharmacy audits as they are performed. 4. The Director of Clinical Services will report the findings of the monitoring to the Quality Assessment and Assurance committee for review and recommendation for the duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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F 431	Continued From page 40	F 431		

On 11/19/2013 at 5:20 p.m. an interview was conducted with nurse # 6. The nurse indicated the medications were expired and should not have been comingled with unexpired medications. The nurse indicated the medications should have been removed and returned to the pharmacy or destroyed and not available for use.

On 11/20/2013 at 2:55 p.m. an observation was made of the ICF unit's medication carts with nurse #1. During the observations of the medication carts the following expired medications were observed:

In the ICF unit's short hall medication cart in the 2nd drawer on right the following medications were observed to be expired:
1 vial of Novolin 70/30 insulin (Lot # CZF0333) pharmacy dispensed 08/30/2013, opened 09/22/2013, expired 10/20/13

1 vial of Novolog insulin (Lot # CZF0323) dispensed 10/12/2013, opened 10/13/2013, expired 11/13/2013

1 vial of Lantus insulin (Lot# A3581) dispensed 08/16/2013, opened 09/28/2013, expired 10/28/2013

1 vial of Novolog insulin (Lot# CZF0323) dispensed 09/26/2013, opened 10/01/2013, expired 11/01/2013

Also in the 2nd drawer of the same medication cart the following insulin medication vials were observed to have been opened and a portion of the insulin used. There was no date on the vials

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F 431	Continued From page 41 or packaging to indicate when the insulin was opened (put into service) or was to expire: 1 vial of Novolog insulin (Lot # CZF0220) dispensed 07/30/2013, no open date or expiration date 1 vial of Novolin R insulin (Lot# CZF0231) dispensed 08/07/2013, no open date or expiration date On 11/20/2013 at 3:00 p.m. an interview was conducted with nurse #6. The nurse indicated the insulin medications were expired and should not have been comingled with unexpired insulin medications. The nurse indicated the medications should have been removed when expired and discarded and not available for use. On 11/20/2013 at 3:12 p.m. an observation was made of the ICF unit's long hall medication cart with nurse # 2. The following insulin medication was observed to be expired. 1 vial of Lantus insulin (Lot# A3564) dispensed 09/11/2013, opened 10/11/2013, expired 11/11/2013 On 11/20/2013 at 3:25 p.m. an observation was made of the ICF unit's wound care treatment cart with nurse #2. The following antibiotic medication was observed to be expired and comingled with unexpired medications. 1 opened and partially used (seal broken) bottle of Nystatin Topical Powder - 100,000 units per gram (Lot# 12G646), opened 10/29/2012. The bottle's labeling indicated - Do not use if protective seal is broken.	F 431		

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F 431	Continued From page 42 On 11/20/2013 at 3:30 p.m. an interview was conducted with nurse # 2. The nurse indicated the medications were expired and should not have been comingled with the unexpired medications. The nurse indicated the medications should have been removed, discarded or returned to the pharmacy and not available for use. On 11/21/2013 at 4:07 p.m. an interview was conducted with the facility's Director of Nursing (DON). The DON indicated her expectation was that expired medications were not to be available for use in the facility. The DON indicated that all nurses should be checking all medications for expiration dates and when expired either discarding the medications or returning the medications to the pharmacy. The DON also indicated the nurses are required to check the insulin labels, insure they are dated when opened; an expiration date is documented on the label and discarded when expired.	F 431		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews the facility failed to ensure a safe environment by not previously identifying and securing a shower grab bar in 1 (Women's common use shower/bathroom) of 3 resident common use shower/bathrooms to aid in	F 456		12/20/13

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F 456	Continued From page 43 physically supporting residents during the shower/bathing process. The findings include: On 11/17/2013 at 12:25 p.m. a tour of the facility was conducted. During the tour an observation was made of the Women's common use shower/bathroom. The observation revealed the safety grab bar in shower stall #3 was loose on the wall and could be moved up and down 1 inch. On 11/17/2013 at 4:00 p.m. a second observation was made of the loose grab bar in the Women's common use shower/bathroom. The grab bar had not been repaired or replaced and was still loose on the wall. On 11/18/2013 at 11:25 a.m. a third observation was made of the loose grab bar in the Women's common use shower/bathroom. The grab bar had not been repaired or replaced and was still loose on the wall. On 11/19/2013 at 7:45 a. m. a fourth observation was made of the loose grab bar in the Women's common use shower/bathroom. The grab bar had not been repaired or replaced and was still loose on the wall. On 11/20/2013 at 10:45 a. m. a fifth observation was made of the loose grab bar in the Women's common use shower/bathroom. The grab bar had not been repaired or replaced and was still loose on the wall. On 11/21/2013 at 1:45 p.m. an interview was conducted with the facility's maintenance director and assistant maintenance director. The maintenance director and assistant explained the facility ' s maintenance request procedure to be:	F 456	**F 456** 1. The shower grab bar in stall #3 in the women's' common use shower/bathroom has been secured to the wall to allow it to aid in physically supporting residents during the shower/bathing process. 2. All grab bars in the facility were assessed for secure anchor into the wall. No grab bars were found to be loosely secured to the wall. The Maintenance Director and Assistant Maintenance Director were re educated by the Executive Director concerning the need to make rounds of the building to check the status of the grab bars. Current Employees have been re educated by the Maintenance Director concerning the reporting of repair needs on the maintenance repair log.	12-20-13

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F 456	Continued From page 44 All staff receive training during their orientation and hire process. They are taught during class that they will fill out a Maintenance Repair Log entry on the forms located at each nurse's station (on the clipboard). Both nurse's stations are checked at random during the day by both the maintenance personnel. The work requested on the logs will be reviewed and prioritized by the assistant and completed unless parts for the repairs are out of stock. If parts are out of stock the maintenance department makes an order through direct support and they send a quote back. Once the quote is approved by corporate the order is finalized and requested from 3rd party vendors. When the parts come in the items are repaired. A review of all of the current work order requests for the facility are reviewed daily by the maintenance personnel. A review of the facility's maintenance requests was conducted with the maintenance personnel. There were no uncompleted work order requests documented on either of the clipboards located at the two nursing stations. The maintenance director indicated all of the work order requests were signed off as being completed. On 11/21/2013 at 1:53 p.m. a sixth observation of the Women's common use shower/bathroom was made with the maintenance director and his assistant. The observation revealed there had been no repair and/or replacement of the loose grab bar. The maintenance director indicated neither he or his assistant had known about the loose grab bar and the grab bar was not listed on the maintenance logs as need to be repaired.	F 456	**F 456 (cont.)** 3. The Maintenance Director or Assistant Maintenance director will document the inspection of the grab bars thru out the facility on the Grab Bar Inspection monitoring tool daily x 7 days, 5 days a week x 3 weeks, weekly x 4 weeks, then monthly x 10 months. 4. The Maintenance Director will report the results of the monitoring to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC is 12/20/2013	12-20-13
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY	F 460		12/20/13

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F 460	Continued From page 45 Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with staff the facility failed to provide full visual privacy for resident occupied semi private rooms. This was evident in 3 of 5 resident halls. (West hall, North Hall, and ICF hall) Findings included: Observation on 11/18/13 at 2:47 PM revealed the privacy curtain in room 115A was insufficient thus creating a gap of 5 feet. There was insufficient privacy curtain around bed 115 B creating a 4 foot gap. Observation on 11/18/13 at 2:50 PM revealed 114 insufficient curtain around the bed A creating an 11-1/2 foot gap. There was insufficient curtain around bed B creating a 7.5 gap. Observation on 11/18/13 at 3:30 PM revealed room 117 Bed A had insufficient privacy curtain thus creating a 4.5 foot gap between the A and B beds. Observation on 11/18/13 at 3:45 PM revealed insufficient privacy curtains for 121 A and B beds thus creating a gap of 7.5 feet for bed A and	F 460	**F 460** 1. Rooms 112, 114, 115,117,121,131, and 132 have adequate curtains in length and width which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. 2. All rooms have been inspected to ensure the curtains provide total visual privacy in combination with adjacent walls and curtains. Extra curtains have been added to augment the present curtains until newly ordered curtains have arrived. The Maintenance Director and Assistant Maintenance Director have been re educated by the Executive Director concerning the expectation that privacy curtains will be long and wide enough to provide total visual privacy in combination with adjacent walls and curtains.	12-20-13

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WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL ST WALNUT COVE, NC 27052

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F 460	Continued From page 46 4.5 feet for bed B. Observation on 11/18/13 at 3:59 PM revealed insufficient privacy curtain for bed 112 A creating a gap of 5 feet. Observation on 11/19/13 at 12 noon revealed the privacy curtains were insufficient in room 131 A and B bed thus creating a gap of 5 foot gap. Observation on 11/20/13 at 10:30 AM of the wound nurse providing care to a resident in room 131 A. The privacy curtain was pulled and did not go completely around the bed in room 131 A. Observations on 11/19/13 at 2:10 PM through 2:20 PM the privacy curtains were still remained insufficient. Observations conducted on 11/18/13 at 2:30 PM revealed no privacy curtain for room 132 A. Observations on 11/19/13 at 5:10 PM and on 11/20/13 at 9:15 AM revealed the resident's privacy curtain was still missing. A staff interview with NA # 6 was conducted 11/20/13 at 3:10 PM regarding care provided to the resident without a privacy curtain. NA #6 indicated not being aware there was not a privacy curtain on the resident's side of the room. The NA indicated the resident could walk to the toilet with assistance, and the resident was taken to the bathroom. The NA also indicated the resident was taken to the shower,and to the bathroom for bed baths, since the resident was able to sit on the toilet and perform self bathing from the sink. The NA did not indicate how privacy was given when care was given to the resident in the bed, since	F 460	**F 460 (cont.)** 3. The Maintenance Director and Assistant Maintenance Director will check the privacy curtains to ensure they comply with the expectations and document the inspection on the Privacy Curtain monitoring tool daily x 7 days, 5 days a week x 3 weeks, weekly x 4 weeks, and then monthly x 10 months. 4. The Maintenance Director will report the results of the monitoring to the Quality Assessment and Assurance committee for review and recommendations for the duration of the scheduled monitoring. 5. AOC is 12/20/2013	12-20-13

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F 460	Continued From page 47 the resident had a roommate.. Interview on 11/21/13 at 9:45 AM with maintenance director revealed the facility converted room 132 from a private room to double occupancy in 2011. The maintenance director indicated the track and the privacy curtain in room 132 was hung on yesterday (referring to 11/20/13). Observations on 11/20/13 on 1:15 PM revealed the resident privacy curtains remained insufficient. Interview on 11/21/13 at 9:30 AM with housekeeper (HK) HK #1 revealed she has been employed at the facility for 12 years. HK #1 indicated that her daily routine included checking privacy curtains to make sure that they were long enough and that the curtains go all the way around the bed. HK #1 indicated she was assigned to 101 through 119 and there were no problems with all the privacy curtains in her assigned rooms. Interview on 11/21/13 at 9:35 AM with HK #2 revealed his routine consisted of walking through his unit when he first comes on duty. HK# 2 indicated the housekeeping staff checks at least once a week for the status of the privacy curtains to see if they are dirty, torn, long or wide enough. Interview on 11/21/13 at 9:40 AM with the assistant HK manager revealed the	F 460		

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F 460	Continued From page 48 housekeeping department was responsible for hanging the privacy curtains. The assistant manager indicated that her staff checks privacy curtains at least every 2 days. We (referring to the housekeeping staff) checked the privacy curtains in all the rooms yesterday (11/20/13) and fixed the rod, track in room 132 and no other privacy curtains needed correcting. Observations on 11/21/13 at 9:58 AM with the maintenance director, housekeeping assistant manager and HK #1 revealed in room 112 revealed the privacy curtains were still insufficient. Interview on 11/22/13 at 4:21 PM with the administrator and director of clinical services was held. The administrator indicated the issues regarding the privacy curtains were never brought to his attention.	F 460		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		12/20/13

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F 520	Continued From page 49 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record reviews the facility failed to implement appropriate plans of action to correct 2 of 2 QAA committee identified quality deficiencies - 1) obtain accurate weights, measurements, and documentation on newly admitted residents; 2) ensure all residents received fluids/hydration between meals. The findings include: An interview and record review was conducted with the facility's administrator on 11/22/2013 at 4:25 p.m. The administrator provided information to show the facility had a QAA committee, that the committee met at least quarterly, and the committee had identified two recent quality deficiencies in the facility that affected the residents care noted as: 1 - Newly admitted residents had inaccurate weights, measurements, and wrong documentation of these items - the resolve was to properly weigh, measure, and document the findings on each newly admitted resident upon admission. The initiation of this quality deficiency was on 10/16/2013 during the QAA committee's meeting and was to be completed by 11/16/2013. 2 - Residents were not receiving proper fluids	F 520	**F 520** 1. Plans have been initiated and monitoring tools have been developed and are being utilized for the monitoring of the identified issues with height and weight documentation with newly admitted residents and adequate hydration fluids between meals offered for all resident. 2. The Executive Director has been re educated by the Regional Vice President of Operations concerning the requirements of the Quality Assessment and Assurance committee in identifying issues, creating plans to address the issue, monitoring the results of the plan, and reviewing the results in the committee meetings for recommendation to the plans.	12-20-13

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F 520	Continued From page 50 (water, juice, coffee, milk, tea etc.) between meals for adequate hydration - the resolve was to ensure residents received adequate hydration fluids between meals. The initiation of this quality deficiency was during the 10/08/2013 QAA committee's meeting and was to be completed by 11/08/2013. The administrator indicated he had no documentation to show how they initiated, conducted, and/or completed the processes to correct the two QAA committee's quality deficiencies. The administrator indicated he had no way to show the facility had developed and implemented appropriate plans of action to correct the QAA committee's identified quality deficiencies. The administrator indicated the MDS coordinator was monitoring the processes for the identified issues. When asked how this was accomplished the administrator indicated the MDS coordinator and DON would have the information if there was any. An interview was conducted with the MDS coordinator on 11/22/2013 at 4:50 p.m. The MDS coordinator was asked how the processes for monitoring the two QAA committee's identified quality deficiencies was conducted and if she had any documentation or other way to show if the identified concerns were implemented, studied, and/or corrected. The MDS coordinator indicated the facility had purchased cloth tape measuring devices to to measure newly admitted residents and handed them out to the units to put on the medication carts but had no documentation to show if they were being used or how the process to correct the problem was accomplished. The MDS coordinator indicated the hall nurses were generally responsible for monitoring the Nursing Assistants (NAs) to ensure they weighed,	F 520	**F 520 (cont.)** 3. The Executive Director will show the documentation of the Quality Assessment and Assurance committee minutes and monitoring forms to the Regional Vice President of Operations or Regional Director of Clinical Operations during visits or by scan/fax with each meeting x 6 months. This will be documented by a statement written by the RVPO or RDCS with each review. 4. The Executive Director will enter the evidence of this review to the Quality Assessment and Assurance for review and recommendation for the duration of the scheduled monitoring. 5. AOC 12/20/2013	12-20-13

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F 520	Continued From page 51 measured, and documented the newly admitted resident's information correctly. The MDS coordinator indicated there was no information she knew of to show the nurses were monitoring the NAs to see if the weights, measurements, and documentation was correct. The MDS coordinator indicated she had no written standard to go by to tell if the NAs were measuring, weighing and documenting the newly admitted resident's information correctly. The MDS coordinator indicated she was never instructed by anyone and had no documentation to show which staff were instructed (in-serviced) on the correct way to take weights or measure newly admitted residents or how it was to be documented. The MDS coordinator indicated there had been no in-service for the staff on this issue as far as she knew. The MDS coordinator indicated she had no way to show which newly admitted residents may have been weighed, measured, and documented on, if any, or who conducted the weighing, measuring and documenting. The MDS coordinator indicated she could not tell if any of the weights, measurements, and/or documentation was accurate, or if the QAA committee's identified quality deficiency was still deficient or if the QAA process needed to be modified to correct ongoing inaccuracies. A review of the QAA committee's completion date for insuring newly admitted resident's weights, measurements, and documentation was documented to be 4 weeks after the documented initiation date of 10/17/2013. The completion date was documented as 11/16/2013. The MDS coordinator could not state if the identified QAA quality deficiency concern was completed or the concern issue was corrected as she had no way to identify what was or was not monitored, completed, and/or documented. The MDS	F 520		

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F 520	Continued From page 52 coordinator indicated she attended the QAA committee's meeting where the quality deficiency issue about the resident's not receiving adequate hydration/fluids between meals had been discussed but did not know what if anything had been done other than it being documented in the QAA committee's notes as a quality deficiency for investigation and correction and the facility was going to do a study on the quality deficiency and correct it. The MDS coordinator indicated she was never told she was to monitor or document anything concerning the quality deficiency of the resident's not receiving receiving adequate fluids between meals and also indicated she believed no one else had either. An interview was conducted with the facility's DON on 11/22/2013 at 5:15 p.m. The DON was asked how the process for monitoring the identified QAA committee's quality deficiencies was conducted and if she had any documentation to show how it was done or if the issues were ever looked at. The DON indicated she knew the facility had purchased cloth tape measuring devices but could not explain and had no documentation to show how the process to correct the quality deficiency of correctly measuring, weighing, and documenting newly admitted resident's information was to be accomplished. The DON indicated she knew the staff were not weighing the facility's residents the same way each time as some were weighed in their wheelchairs, some not, some with multiple layers of winter clothing on and some not, others residents were being weighed with their canes and walkers on the scale. The DON was not sure how or who was responsible for monitoring the nurses and NAs or how the measuring, weighing and documenting the newly admitted resident's	F 520		

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F 520	Continued From page 53 information was to be accomplished (standards) or if it had been done at all. The DON indicated she had no documentation or way to show who (which staff) was instructed on how to weigh, measure, and document the resident's information correctly. The DON indicated they had no way to show which newly admitted residents had been weighed, measured, and documented on or if the weights, measurements, and documentation were accurate. The DON indicated she did not know if the QAA committee's quality deficiency concern was corrected or if the facility had developed and implemented an appropriate plan of action to correct the quality deficiency. The DON indicated she had no way to identify what was or was not monitored and/or completed. The DON indicated she knew about the QAA committee's identified quality deficiency concerning the residents not receiving fluids/hydration between meals. The DON did not know if the identified quality deficiency issue had been studied, what halls/units may have been observed or monitored, what staff had been identified - if any as not providing the fluids between meals, if resident water cups/pitchers were being filled between meals or what the outcomes, if any, were. The DON indicated she had no documentation or other way to show the QAA committee's identified quality deficiency of residents not receiving adequate fluids/hydration between meals had been studied and corrected.	F 520		