

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

PRINTED: 05/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/09/2014
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
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F 242	<p>Continued From page 1</p> <p>the facility how many showers he'd like to receive each week and he was not aware that any resident there had a choice about their shower frequency. Resident #119 stated if given a choice, he would prefer to have three or four showers weekly instead of the two assigned to him.</p> <p>Interview with Nurse Aide (NA) #2 on 05/07/14 at 10:48 AM revealed all residents got two baths or showers per week, scheduled by their room numbers. NA #2 stated a couple of residents in the facility got three showers a week, because their families had requested the additional shower in writing to the administrator. NA #2 stated residents were frequently surprised at the shower schedule when first admitted and tell her they've taken showers every day of their lives until coming here. She stated she explained to them in the facility, all residents were scheduled two showers each week and she reminded residents frequently which days were their scheduled shower days. NA #2 presented the facility shower schedule which was posted at the nurse's desk. Review of the shower schedule revealed Resident #119 was assigned showers on Tuesdays and Fridays.</p> <p>Interview with Nurse #8 on 05/07/14 at 2:05 PM revealed a set shower schedule was kept at the nursing station which assigned each resident two showers weekly according to their room numbers. Nurse #8 stated she was unaware of any nurse or nurse aides who asked residents about their shower frequency preferences.</p> <p>Interview with the Senior Care Partner on 05/08/14 at 8:38 AM revealed residents were told at admission about the shower schedule kept at</p>	F 242	<p><i>Continued from page 1</i></p> <p>Clinical Competency Coordinator or designee will educate nursing staff on the new bathing preference and scheduling process.</p> <p>The Senior Care Partner/Designee will validate with all new admissions and re-admission the integration of the residents bathing preference onto Resident Care Plan and CNA/ ADL guide.</p> <p>Education on preference process will be provided to Interdisciplinary team by Clinical competency Coordinator/designee</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance</p> <p>Senior Care Partner/Designee will maintain log of all Admissions and Re-Admission preferences .</p> <p>Log of admitting preferences will be reviewed by Interdisciplinary team weekly for four weeks then monthly for four months.</p> <p>Education will be provided to new partners upon general and job specific orientation on bathing schedules and preferences.</p>	<p>June 6, 2014</p> <p>June 6, 2014</p> <p>June 6, 2014</p> <p>June 6, 2014</p> <p>June 6, 2014</p>	

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F 242	<p>Continued From page 2</p> <p>each nursing station, which assigned each resident room to two shower days per week. The Senior Care Partner stated if a resident or family member came to her with a specific request of shower frequency change, she would work with staff and family to accommodate that request. The Senior Care Partner stated she did not assess shower preferences unless a problem with the posted shower days was brought to her attention by the resident or family.</p> <p>Interview with Nurse #2 on 05/08/14 at 3:05 PM revealed showers were scheduled twice weekly according to resident room numbers. Nurse #2 stated facility staff did not go to each resident and assess their preferences regarding shower frequency but if a resident or family member approached staff with a schedule change request, they would make an effort to work the change into the nurse aide schedule.</p> <p>Interview with Nurse #4 on 05/09/14 at 10:08 AM revealed each unit had a shower schedule that provided residents with two showers per week based on their room number. Nurse #4 stated during resident initial admission assessment, residents were asked about the type of bath or shower the resident preferred and whether the resident preferred their shower to be provided during the morning or the evening, but residents' shower frequency preferences were not assessed. Nurse #4 stated when a resident requested an extra shower the staff attempted to fit it in but it was rare staff were able to do so.</p> <p>Interview with Director of Social Services on 05/09/14 at 11:58 AM revealed residents were provided two showers or baths weekly based on their room number and the existing shower</p>	F 242	<p><i>Continued from page 2</i></p> <p>All reports will be submitted to Quality Assurance and Performance Improvement Committee monthly for validation of compliance with update/change as indicated.</p>	June 6, 2014	

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F 242	<p>Continued From page 3</p> <p>schedule, which had been developed to make sure each resident received two showers and nurse aide schedules were fair and balanced. The Director of Social Services stated she was not aware of any facility staff including an assessment for shower frequency preferences in their resident assessments.</p> <p>Interview with the Director of Nursing (DON) on 05/09/14 at 12:44 PM revealed residents were told about their two scheduled shower days upon admission. The DON stated showers were split between the morning and evening hours on Mondays through Saturdays so that each resident got two showers a week and the nurse aide shower load was not too heavy on any day. The DON stated an assessment of resident shower frequency preferences was not part of their assessments.</p> <p>Interview with the Activities Director on 05/09/14 at 1:09 PM revealed she was not aware of any staff member who assessed resident shower frequency preferences. The Activities Director stated a shower schedule existed that assigned two shower days per week to each resident but residents were asked if they preferred to have their assigned shower in the morning or evening.</p> <p>2. Resident #126 was admitted to the facility on 04/28/14 with diagnoses which included chronic airway obstruction, venous insufficiency, neuropathy, and glaucoma. Although Resident #126 had not yet been formally assessed for cognition or ability to understand by facility staff, the director of nursing submitted Resident #126's name in a list of residents who were alert and oriented at the initiation of the survey.</p>	F 242			

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F 242	<p>Continued From page 4</p> <p>Interview with Resident #126 on 05/05/14 at 3:45 PM revealed he had always taken a bath or shower daily until entering the facility and would prefer to have them much more than twice weekly. Resident #126 stated he was told of the shower schedule assigned to his room, showers on Monday and Thursday, when he was admitted and was never asked about his preferences. Resident #126 stated when he had asked for an additional shower, he had been reminded of the next day he was scheduled to receive a shower.</p> <p>Interview with Nurse Aide (NA) #2 on 05/07/14 at 10:48 AM revealed all residents got two baths or showers per week, scheduled by their room numbers. NA #2 stated a couple of residents in the facility got three showers a week, because their families had requested the additional shower in writing to the administrator. NA #2 stated residents were frequently surprised at the shower schedule when first admitted and tell her they've taken showers every day of their lives until coming here. She stated she explained to them in the facility, all residents were scheduled two showers each week and she reminded residents frequently which days were their scheduled shower days. NA #2 presented the facility shower schedule which was posted at the nurse's desk. Review of the shower schedule revealed Resident #126 was assigned showers on Mondays and Thursdays.</p> <p>Interview with Nurse #8 on 05/07/14 at 2:05 PM revealed a set shower schedule was kept at the nursing station which assigned each resident two showers weekly according to their room numbers. Nurse #8 stated she was unaware of any nurse or nurse aides who asked residents about their shower frequency preferences.</p>	F 242			

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F 242	Continued From page 5 Interview with the Senior Care Partner on 05/08/14 at 8:38 AM revealed residents were told at admission about the shower schedule kept at each nursing station, which assigned each resident room to two shower days per week. The Senior Care Partner stated if a resident or family member came to her with a specific request of shower frequency change, she would work with staff and family to accommodate that request. The Senior Care Partner stated she did not assess shower preferences unless a problem with the posted shower days was brought to her attention by the resident or family. Interview with Nurse #2 on 05/08/14 at 3:05 PM revealed showers were scheduled twice weekly according to resident room numbers. Nurse #2 stated facility staff did not go to each resident and assess their preferences regarding shower frequency but if a resident or family member approached staff with a schedule change request, they would make an effort to work the change into the nurse aide schedule. Interview with Nurse #4 on 05/09/14 at 10:08 AM revealed each unit had a shower schedule that provided residents with two showers per week based on their room number. Nurse #4 stated during resident initial admission assessment residents were asked about the type of bath or shower the resident preferred and whether the resident preferred their shower to be provided during the morning or the evening, but residents' shower frequency preferences were not assessed. Nurse #4 stated when a resident requested an extra shower the staff attempted to fit it in but it was rare staff were able to do so.	F 242		

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F 242	<p>Continued From page 6</p> <p>Interview with Director of Social Services on 05/09/14 at 11:58 AM revealed residents were provided two showers or baths weekly based on their room number and the existing shower schedule, which had been developed to make sure each resident received two showers and nurse aide schedules were fair and balanced. The Director of Social Services stated she was not aware of any facility staff including an assessment for shower frequency preferences in their resident assessments.</p> <p>Interview with the Director of Nursing (DON) on 05/09/14 at 12:44 PM revealed residents were told about their two scheduled shower days upon admission. The DON stated showers were split between the morning and evening hours on Mondays through Saturdays so that each resident got two showers a week and the nurse aide shower load was not too heavy on any day. The DON stated an assessment of resident shower frequency preferences was not part of their assessments.</p> <p>Interview with the Activities Director on 05/09/14 at 1:09 PM revealed she was not aware of any staff member who assessed resident shower frequency preferences. The Activities Director stated a shower schedule existed that assigned two shower days per week to each resident but residents were asked if they preferred to have their assigned shower in the morning or evening.</p> <p>3. Resident #123 was admitted to the facility on 04/23/14 with diagnoses which included neuropathy, muscle weakness, and cervical spondylosis. Although Resident #123 had not yet been formally assessed for cognition or ability to understand by facility staff, the director of nursing</p>	F 242			

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F 242	<p>Continued From page 7</p> <p>submitted Resident #123's name in a list of residents who were alert and oriented at the initiation of the survey.</p> <p>Interview with Resident #123 on 05/06/14 at 8:16 AM revealed he had gotten showers daily at home and since being admitted to the facility, he had only received showers about once each week. Resident #123 stated he was upset that he wasn't offered showers more frequently and no staff had asked him about his preferences or offered him any options about shower frequency.</p> <p>Interview with Nurse Aide (NA) #2 on 05/07/14 at 10:48 AM revealed all residents got two baths or showers per week, scheduled by their room numbers. NA #2 stated a couple of residents in the facility got three showers a week, because their families had requested the additional shower in writing to the administrator. NA #2 stated residents were frequently surprised at the shower schedule when first admitted and tell her they've taken showers every day of their lives until coming here. She stated she explained to them in the facility, all residents were scheduled two showers each week and she reminded residents frequently which days were their scheduled shower days. NA #2 presented the facility shower schedule which was posted at the nurse's desk.. Review of the shower schedule revealed Resident #123 was assigned showers on Mondays and Thursdays.</p> <p>Interview with Nurse #8 on 05/07/14 at 2:05 PM revealed a set shower schedule was kept at the nursing station which assigned each resident two showers weekly according to their room numbers. Nurse #8 stated she was unaware of any nurse or nurse aides who asked residents about their</p>	F 242			

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F 242	<p>Continued From page 8 shower frequency preferences.</p> <p>Interview with the Senior Care Partner on 05/08/14 at 8:38 AM revealed residents were told at admission about the shower schedule kept at each nursing station, which assigned each resident room to two shower days per week. The Senior Care Partner stated if a resident or family member came to her with a specific request of shower frequency change, she would work with staff and family to accommodate that request. The Senior Care Partner stated she did not assess shower preferences unless a problem with the posted shower days was brought to her attention by the resident or family.</p> <p>Interview with Nurse #2 on 05/08/14 at 3:05 PM revealed showers were scheduled twice weekly according to resident room numbers. Nurse #2 stated facility staff did not go to each resident and assess their preferences regarding shower frequency but if a resident or family member approached staff with a schedule change request, they would make an effort to work the change into the nurse aide schedule.</p> <p>Interview with Nurse #4 on 05/09/14 at 10:08 AM revealed each unit had a shower schedule that provided residents with two showers per week based on their room number. Nurse #4 stated during resident initial admission assessment residents were asked about the type of bath or shower the resident preferred and whether the resident preferred their shower to be provided during the morning or the evening, but residents' shower frequency preferences were not assessed. Nurse #4 stated when a resident requested an extra shower the staff attempted to fit it in but it was rare staff were able to do so.</p>	F 242			

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F 242	Continued From page 9 Interview with Director of Social Services on 05/09/14 at 11:58 AM revealed residents were provided two showers or baths weekly based on their room number and the existing shower schedule, which had been developed to make sure each resident received two showers and nurse aide schedules were fair and balanced. The Director of Social Services stated she was not aware of any facility staff including an assessment for shower frequency preferences in their resident assessments. Interview with the Director of Nursing (DON) on 05/09/14 at 12:44 PM revealed residents were told about their two scheduled shower days upon admission. The DON stated showers were split between the morning and evening hours on Mondays through Saturdays so that each resident got two showers a week and the nurse aide shower load was not too heavy on any day. The DON stated an assessment of resident shower frequency preferences was not part of their assessments. Interview with the Activities Director on 05/09/14 at 1:09 PM revealed she was not aware of any staff member who assessed resident shower frequency preferences. The Activities Director stated a shower schedule existed that assigned two shower days per week to each resident but residents were asked if they preferred to have their assigned shower in the morning or evening. 4. Resident #125 was admitted to the facility on 04/22/14 with diagnoses which included muscle weakness, debility, and atrial fibrillation. The most recent Minimum Data Set (MDS), an admission MDS dated 04/27/14 indicated the	F 242			

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F 242	<p>Continued From page 10</p> <p>resident was cognitively intact and able to understand and make himself understood. The MDS also indicated Resident #125 needed physical help in part of the bathing activity, requiring the assistance of two or more persons.</p> <p>Interview with Resident #125 on 05/06/14 at 8:39 AM revealed he had always taken a hot bath or shower each day at home but since his admission to the facility, he had only received about two baths. Resident #125 stated he felt he needed more showers than what he was offered and he was very offended that the staff had never asked him how many he would like or if he was satisfied with the schedule. Resident #125 stated he had been told which days his showers were scheduled by nurse aides.</p> <p>Interview with Nurse Aide (NA) #2 on 05/07/14 at 10:48 AM revealed all residents got two baths or showers per week, scheduled by their room numbers. NA #2 stated a couple of residents in the facility got three showers a week, because their families had requested the additional shower in writing to the administrator. NA #2 stated residents were frequently surprised at the shower schedule when first admitted and tell her they've taken showers every day of their lives until coming here. She stated she explained to them in the facility, all residents were scheduled two showers each week and she reminded residents frequently which days were their scheduled shower days. NA #2 presented the facility shower schedule which was posted at the nurse's desk. Review of the shower schedule revealed Resident #125 was assigned showers on Mondays and Thursdays.</p> <p>Interview with Nurse #8 on 05/07/14 at 2:05 PM</p>	F 242			

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F 242	<p>Continued From page 11</p> <p>revealed a set shower schedule was kept at the nursing station which assigned each resident two showers weekly according to their room numbers. Nurse #8 stated she was unaware of any nurse or nurse aides who asked residents about their shower frequency preferences.</p> <p>Interview with the Senior Care Partner on 05/08/14 at 8:38 AM revealed residents were told at admission about the shower schedule kept at each nursing station, which assigned each resident room to two shower days per week. The Senior Care Partner stated if a resident or family member came to her with a specific request of shower frequency change, she would work with staff and family to accommodate that request. The Senior Care Partner stated she did not assess shower preferences unless a problem with the posted shower days was brought to her attention by the resident or family.</p> <p>Interview with Nurse #2 on 05/08/14 at 3:05 PM revealed showers were scheduled twice weekly according to resident room numbers. Nurse #2 stated facility staff did not go to each resident and assess their preferences regarding shower frequency but if a resident or family member approached staff with a schedule change request, they would make an effort to work the change into the nurse aide schedule.</p> <p>Interview with Nurse #4 on 05/09/14 at 10:08 AM revealed each unit had a shower schedule that provided residents with two showers per week based on their room number. Nurse #4 stated during resident initial admission assessment residents were asked about the type of bath or shower the resident preferred and whether the resident preferred their shower to be provided</p>	F 242			

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F 242	<p>Continued From page 12</p> <p>during the morning or the evening, but residents' shower frequency preferences were not assessed. Nurse #4 stated when a resident requested an extra shower the staff attempted to fit it in but it was rare staff were able to do so.</p> <p>Interview with Director of Social Services on 05/09/14 at 11:58 AM revealed residents were provided two showers or baths weekly based on their room number and the existing shower schedule, which had been developed to make sure each resident received two showers and nurse aide schedules were fair and balanced. The Director of Social Services stated she was not aware of any facility staff including an assessment for shower frequency preferences in their resident assessments.</p> <p>Interview with the Director of Nursing (DON) on 05/09/14 at 12:44 PM revealed residents were told about their two scheduled shower days upon admission. The DON stated showers were split between the morning and evening hours on Mondays through Saturdays so that each resident got two showers a week and the nurse aide shower load was not too heavy on any day. The DON stated an assessment of resident shower frequency preferences was not part of their assessments.</p> <p>Interview with the Activities Director on 05/09/14 at 1:09 PM revealed she was not aware of any staff member who assessed resident shower frequency preferences. The Activities Director stated a shower schedule existed that assigned two shower days per week to each resident but residents were asked if they preferred to have their assigned shower in the morning or evening.</p>	F 242		
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F 242	<p>Continued From page 13</p> <p>5. Resident #40 was admitted to the facility on 04/18/14 with diagnoses which included chronic pain syndrome, atrial fibrillation, and cellulitis. Although Resident #123 had not yet been formally assessed for cognition or ability to understand by facility staff, the admission assessment indicated the resident was alert, oriented, and comprehended all information.</p> <p>Interview with Resident #40 on 05/06/14 at 9:51 AM revealed when living at home, he had usually taken one shower weekly. Resident #40 stated he would rather take one shower each week but the facility staff made him take two. Resident #40 stated he was very nervous about the power of the jets in the whirlpool tub used to bathe him twice weekly. He stated the jets were really strong, calling the tub a powerful machine and he had never experienced anything like that. Resident #40 stated he didn't like the way his foot wound felt when it was wet and the powerful water was going, and there was no way he could control the water and it frightened him. As a result of his feelings, Resident #40 stated he didn't want to be bathed or showered more than once weekly but he had no choice.</p> <p>Review of Resident #40's medical record revealed no medical order for whirlpool bath or frequency of baths/showers related to foot wound.</p> <p>Interview with Nurse Aide (NA) #2 on 05/07/14 at 10:48 AM revealed all residents got two baths or showers per week, scheduled by their room numbers. NA #2 stated a couple of residents in the facility got three showers a week, because their families had requested the additional shower in writing to the administrator. NA #2 stated</p>	F 242		
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F 242	<p>Continued From page 14</p> <p>residents were frequently surprised at the shower schedule when first admitted and tell her they've taken showers every day of their lives until coming here. She stated she explained to them in the facility, all residents were scheduled two showers each week and she reminded residents frequently which days were their scheduled shower days. NA #2 presented the facility shower schedule which was posted at the nurse's desk. Review of the shower schedule revealed Resident #40 was assigned showers on Tuesdays and Fridays. .</p> <p>Interview with Nurse #8 on 05/07/14 at 2:05 PM revealed a set shower schedule was kept at the nursing station which assigned each resident two showers weekly according to their room numbers. Nurse #8 stated she was unaware of any nurse or nurse aides who asked residents about their shower frequency preferences.</p> <p>Interview with the Senior Care Partner on 05/08/14 at 8:38 AM revealed residents were told at admission about the shower schedule kept at each nursing station, which assigned each resident room to two shower days per week. The Senior Care Partner stated if a resident or family member came to her with a specific request of shower frequency change, she would work with staff and family to accommodate that request. The Senior Care Partner stated she did not assess shower preferences unless a problem with the posted shower days was brought to her attention by the resident or family.</p> <p>Interview with Nurse #4 on 05/08/14 at 9:22 AM revealed Resident #40 's daughter had requested the whirlpool tub be used once weekly at admission, but residents in the facility all</p>	F 242			

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F 242	<p>Continued From page 15</p> <p>received twice weekly baths or showers. Nurse #6 stated Resident #40 was alert, oriented, and reliable with information, but he was not aware of Resident #40' bathing type or frequency preferences.</p> <p>Interview with Nurse #2 on 05/08/14 at 3:05 PM revealed showers were scheduled twice weekly according to resident room numbers. Nurse #2 stated facility staff did not go to each resident and assess their preferences regarding shower frequency but if a resident or family member approached staff with a schedule change request, they would make an effort to work the change into the nurse aide schedule.</p> <p>Interview with Nurse #4 on 05/09/14 at 10:08 AM revealed each unit had a shower schedule that provided residents with two showers per week based on their room number. Nurse #4 stated during resident initial admission assessment residents were asked about the type of bath or shower the resident preferred and whether the resident preferred their shower to be provided during the morning or the evening, but residents shower frequency preferences were not assessed. Nurse #4 stated when a resident requested an extra shower the staff attempted to fit it in but it was rare staff were able to do so.</p> <p>Interview with Director of Social Services on 05/09/14 at 11:58 AM revealed residents were provided two showers or baths weekly based on their room number and the existing shower schedule, which had been developed to make sure each resident received two showers and nurse aide schedules were fair and balanced. The Director of Social Services stated she was not aware of any facility staff including an</p>	F 242			

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F 242	Continued From page 16 assessment for shower frequency preferences in their resident assessments. Interview with the Director of Nursing (DON) on 05/09/14 at 12:44 PM revealed residents were told about their two scheduled shower days upon admission. The DON stated showers were split between the morning and evening hours on Mondays through Saturdays so that each resident got two showers a week and the nurse aide shower load was not too heavy on any day. The DON stated an assessment of resident shower frequency preferences was not part of their assessments. Interview with the Activities Director on 05/09/14 at 1:09 PM revealed she was not aware of any staff member who assessed resident shower frequency preferences. The Activities Director stated a shower schedule existed that assigned two shower days per week to each resident but residents were asked if they preferred to have their assigned shower in the morning or evening.	F 242			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to replace an ordered, non-functioning alarming fall mat for 1 of 1 resident (Resident #84) and failed to clean a common use bath tub for 1 of 2 resident tubs.	F 253	What corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident #84 Plan of Care updated to reflect no falls for the last 90 days. Physicians orders obtained to discontinue floor alarm mats , bed and chair alarms	May 9, 2014 May 12, 2014	

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F 253	<p>Continued From page 17</p> <p>Findings included:</p> <p>1. Resident #84 was admitted to the facility on 04/30/13 with diagnoses including dementia and convulsions. The most recent Minimum Data Set (MDS) dated 02/07/14 coded Resident #84 with severely impaired cognition, requiring total 2 person assistance with all activities of daily living and with range of motion impairment on both sides of his body and with all extremities. The Care Area Assessment triggered for falls due to impaired balance, seizure disorder and a history of falls prior to his admission. His care plan reviewed on 02/07/14 included the risk for falls with various and appropriate interventions.</p> <p>Review of Resident #84's monthly physician orders for May, 2014 revealed the current order for "floor mats w [with] alarms to each side of bed while in bed, check placement and function q [every] shift." Review of treatment records for May, 2014 revealed transcription of this order with nurse initials noted on all days and all shifts for the period of 05/06/14 through 05/08/14.</p> <p>An observation on 05/06/2014 at 9:53 AM of Resident #84's room revealed a floor mat on the right side of the bed with a broken connecting cord. An alarm was observed connected to the floor mat on the left side but with no signal. Nurse Aide (NA) #5 was observed checking the bed alarm and floor mat alarms and stated the floor mat on the right side of the bed had a broken wire. Nurse Aide (NA) #5 was observed walking over both floor mats and stated the alarms did not sound, the floor mats were not working and she was observed leaving the room after care was completed.</p>	F 253	<p><i>Continued from page 17</i></p> <p>Common Use Bath Tubs/Spa cleaned by Environmental Services</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Sign place on Door by Maintenance Department for "Out of Order" to prevent any bathing in specified tub/spa until repair complete</p> <p>Visual posted instructions placed in each Tub/spa room to ensure proper cleaning after use.</p> <p>Audit performed by Maintenance Department for any additional alarming floor mats. No additional Residents with alarming floor mats identified.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will no reoccur?</p> <p>Clinical Competency Coordinator or designee will educate the Certified Nursing Assistants on proper sanitation of tub/spa after each use</p>	May 9, 2014	May 9, 2014	May 9, 2014	May 30, 2014	June 6, 2014

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F 253	Continued From page 18 An observation on 05/06/14 at 1:58 PM of Resident #84's room revealed the resident in bed with a visitor. The floor mat on the right side of the bed was observed with a broken connecting cord. An alarm was observed connected to the floor mat on the left side but with no signal. Upon stepping on the floor mats no alarm sounded. An observation on 05/07/14 at 7:41 AM of Resident #84's room revealed the floor mat on the right side of the bed with a broken connecting cord. An alarm was observed connected to the floor mat on the left side but with no signal. Upon stepping on the floor mats no alarm sounded. An observation on 05/09/14 at 7:01 AM of Resident #84's room revealed Nurse #1 outside the room and standing at a medication cart. The resident was observed sleeping in his bed in a low position. A floor mat was observed on the right side of the bed with a connecting cord lying across it with exposed copper wire. An alarm box was observed lying on a bedside table to the right of the bed with no blinking light and no attached cord. Alarm boxes were observed hanging on the left and right upper bed rails, both with a green blinking light. An interview on 05/09/14 at 7:06 AM with Nurse #1 revealed she had just been in Resident #84's room to administer morning medications. She stated staff knew alarmed floor mats were working when staff stepped on them and an alarm would sound. She stated if activated the alarm box showed a blinking green light and if the floor mat connecting cord was removed from the alarm box it would blink red. Nurse #1 was observed stepping on the floor mat to the left side of the bed and it did not alarm. Nurse #1	F 253	<i>Continued from page 18</i> Night shift Supervisor to check tubs/spa's for cleanliness daily Education provided to staff regarding "Work Order" report submission for broken/non functioning equipment. Environmental Services Department to place Common Use Tubs/Spa on weekly deep cleaning schedule How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what Quality assurance program will be put in place for monitoring to assure continued compliance? Nursing Services, Maintenance Department or Environmental Services will monitor common bathing areas three times a week for four weeks, then weekly for four weeks, then monthly for four months Education will be provided to new partners upon general and job specific orientation on notifying the Maintenance Department of all equipment not working properly and how to clean common use tubs.	June 6, 2014 June 6, 2014 June 6, 2014 June 6, 2014 June 6, 2014	

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F 253	<p>Continued From page 19</p> <p>unplugged the connecting cord from the alarm box and it blinked red. She stated she was in the room earlier that morning to perform a blood glucose finger stick and at that time moved the pad away so as to prevent the alarm from sounding if she stepped on the mat. Nurse #1 was observed looking at the connecting cord lying on top of the fall mat to the right side of the bed and stated the cord was broken. Nurse #1 was observed picking up the alarm box on the bedside table to the right of the bed and stated a plastic cord connector was stuck in the box and stated the cord was broken from the connector. Nurse #1 stated staff were expected to complete work request forms for broken equipment and put them in a box at the front desk. She stated it was expected that broken equipment was to be reported immediately and not be left in resident rooms. She stated NAs were expected to check pad alarms each shift to make sure they were functioning properly.</p> <p>An interview on 05/09/14 at 7:13 AM with NA #1 revealed she was assigned to Resident #84 but had not yet been in his room to get him up, she normally was not assigned to his unit and she had not worked in days. She stated the NA assigned to the night shift whom she relieved, but could not remember her name, stated everything was fine with Resident #84 and did not speak anything concerning his alarms. She stated when she first walked into a room with alarmed floor mats, she would step on the mat to make sure the alarm would go off, then she would unplug it to make sure it also alarmed.</p> <p>An observation on 05/09/14 at 7:18 AM revealed NA #1 entering Resident #84's room, stepping on the floor mat to the left side of the bed and</p>	F 253	<p><i>Continued from page 19</i></p> <p>All reports will be submitted to Quality Assurance and Performance Improvement Committee monthly for four months for validation of compliance.</p>	June 6, 2014	

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F 253	<p>Continued From page 20</p> <p>observing no alarm. NA #1 unplugged the connecting cord from this fall mat to the alarm box hanging on left bed rail and the alarm sounded. She stated when she stepped on the floor mat the alarm should have gone off. NA #1 was observed moving to the right side of the resident's bed, looking at the connecting cord lying across the floor mat and stated it should have been attached to an alarm box. NA #1 was observed picking up the alarm box lying on the bedside table to the right of the resident's bed and stated the plastic cord connector was broken off in the box. She stated this alarm box was probably for the floor mat on the right side of Resident #84's bed. She stated when equipment was found broken the expectation was to report it to the nurse.</p> <p>An interview on 05/09/14 at 8:20 AM with the Director of Nursing (DON) revealed if alarms were not working staff were to use the reporting system in place with the maintenance director. She stated staff were expected to check alarms when in place.</p> <p>An observation on 05/09/14 at 8:30 AM with the DON of Resident #84's room revealed his floor mats leaning up against wall behind his bed. The DON was observed picking up the connecting cord to the floor mat against the wall on the right side of the bed and stated it was clearly broken and staff should have reported it.</p> <p>2. Review of a printed bath schedule for Bravo Unit revealed numerous handwritten comments in the margins and body of the printed schedule of resident room numbers desiring a bath on Mondays and Thursdays. In the printed schedule next to one room number was the handwritten</p>	F 253			

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F 253	<p>Continued From page 21</p> <p>word "whirlpool." A review of a printed bath schedule for Charlie Unit revealed the handwritten word "whirlpool" next to numerous rooms on Wednesdays and Saturdays. An observation on 05/05/14 at 9:00 AM of spa room E59, in the hallway between Bravo and Charlie units, revealed a whirlpool type tub that was wet and clean.</p> <p>An observation on 05/06/14 at 12:10 PM of spa room E59 revealed a whirlpool type tub that was dry with an approximate 1 inch wide gray and greasy ring was observed midway up the inside of the tub. Similar observations were made on 05/07/14 at 7:56 AM and on 05/08/14 at 11:22 AM.</p> <p>An interview on 05/08/14 at 10:00 AM with Nurse Aide (NA) #2 revealed she was aware of availability of the whirlpool tub for residents but stated not many residents used it. She stated there was a cleaning solution in a compartment as a part of the tub that was used by spraying down the tub after use but she was not sure if housekeeping staff had to sanitize it on a daily basis.</p> <p>An interview on 05/08/14 at 2:39 PM with NA #3 revealed his awareness that some residents received tub baths but he was not sure who they were. He stated after the resident was removed from the tub and returned to the unit, NAs were expected to return to the tub room to clean the tub, with cleaning supplies in the room. He stated it was not hard to clean the tub but it was expected after the bath so it would be ready for the next resident.</p> <p>An interview on 05/08/14 at 3:06 PM with the</p>	F 253		
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F 253	<p>Continued From page 22</p> <p>Director of Nursing (DON) stated tub bathing was recommended for residents with risk of skin breakdown to stimulate blood flow and debride as necessary, as requested by residents. She stated NAs who assisted with the baths were expected to clean the tub. She stated housekeeping looked at the tubs for cleanliness but they did not clean them as part of their set routine.</p> <p>An observation on 05/08/14 at 3:10 PM of room E59 with the DON and Unit Manager revealed a whirlpool type tub that was dry with an approximate 1 inch wide gray and greasy ring was observed midway up the inside of the tub. The DON stated the tub was recently broken and there was at one time a sign on the door. The Unit Manager stated the sign had not been up all week and no cleaning supplies were to be left in the tub room.</p> <p>An interview on 05/08/14 at 3:15 PM with NA #4, in the presence of the Unit Manager, revealed it had been a while since she gave a bath to a resident but when she did cleaning supplies were found in the tub room. The Unit Manager stated she did not know where cleaning supplies were kept.</p> <p>An interview on 05/08/14 at 3:29 PM with the Maintenance Director, in the presence of the Unit Manager, revealed the tub in room E59 functioned properly, but due to hot water demands on the units, staff had to make sure multiple residents were not taking showers while someone was in the tub. The Unit Manager stated the housekeeping supervisor was not available for an interview but he had told her the NAs were expected to find housekeeping staff to</p>	F 253			

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F 279	Continued From page 24 of 2 residents reviewed for well being (Residents #13 and #127). The findings included: 1. Resident #13 was admitted to the facility on 10/24/12 with diagnoses which included anemia, Alzheimer's disease, strokes, generalized muscle weakness, constipation, and diarrhea. The Quarterly Minimum Data Set (MDS) dated 03/24/14 coded Resident #13 with moderately impaired decision making skills, and long and short term cognitive impairment. The MDS further coded Resident #13 for required extensive staff assistance with bed mobility, transfers, dressing, and toileting, and was always incontinent of bowel and frequently incontinence of bladder. A review of the bowel report records for January 2014 indicated Resident #13 had 31 watery liquid stools documented in 19 days with the nurse notified notation, 10 of the 19 days were documented with multiple watery stools. A review of the bowel report records for February 2014 indicated Resident #13 had 32 watery liquid stools documented in 18 days with the nurse notified notation, 11 of the 18 days were documented with multiple watery stools. A review of the bowel report records for March 2014 indicated Resident #13 had 27 watery liquid stools in 17 days with the nurse notified notation, 7 of the 17 days were documented with multiple watery stools. During the March 16th through the 20th period Resident #13 was noted to have 10 watery liquid stools during that 5 day time frame with the nurse notified notation.	F 279	<i>Continued from page 24</i> Director of Health Services or designee will perform an audit of all admissions/Re-admissions last 30 days to identify any additional residents at risk for loose stools or skin integrity issues. Evaluation, intervention, reporting and documentation will follow as indicated. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Nursing will pull data from Bowel Elimination Report and "No BM" Report from Electronic Medical Record as well as 24 hour report daily and follow policy/protocol for action regarding loose stools as needed. Licensed Nurse to educate C.N.A. immediately if discrepancy found between electronic BM documentation and C.N.A. documentation of loose stools on 24 hour report. Certified Nursing Assistants educated to notify nurse of all loose stools via facility report 24 hour report tool. Electronic Medical Record SMART Chart for CNA's automatically sends nurse notified to Nurse when loose stool/watery stool is selected during documentation	June 6, 2014	June 6, 2014

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F 279	<p>Continued From page 25</p> <p>A review of the bowel report records for April 2014 indicated Resident #13 had 19 watery liquid stools documented in 15 days with the nurse notified notation, 4 of the 15 days were documented with multiple watery stools.</p> <p>A review of the bowel report records dated 05/01/14 through 05/08/14 reflected Resident #13 had 3 days with watery liquid stools documented with the nurse notified notation.</p> <p>A review of the physician's progress notes dated 03/18/14 indicated Resident #13 was seen due to nursing staff request for evaluation regarding complaints of nausea, vomiting and diarrhea. The physician's physical exam indicated Resident #13's abdomen was soft and diffusely tender and nursing staff had reported vomiting and diarrhea. The physician's plan indicated adding the medication Imodium 2 mg by mouth every 6 hours for diarrhea, monitor closely and notify the physician immediately for any changes in his condition.</p> <p>A review of the physician orders dated 03/18/14 revealed an order written for Imodium (medication for diarrhea) 2 mg by mouth every 6 hours as needed for diarrhea.</p> <p>A review of the care plans revealed the last review was dated 03/24/14. The care plan problems addressed were constipation, history of weight loss and nurse assistant care interventions. No care plan was in place for diarrhea to review.</p> <p>On 05/05/14 at 1:47 PM Resident #13 was observed during incontinent care and had a brief</p>	F 279	<p><i>Continued from page 25</i></p> <p>Nurses educated on immediate update of Interim/Individualized Care plan, physician notification, Skin Integrity Coordinator notification, and initiation of treatment if indicated for any skin integrity issues found during resident assessment.</p> <p>C.N.A's to be educated on immediate reporting of any skin integrity issues to licensed nurse on duty on that unit.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance?</p> <p>Skin Integrity Coordinator will monitor new admissions with areas with skin integrity issues twice per week for four weeks, then weekly for four weeks, then monthly for four months. :</p> <p>Education will be provided to new partners upon general and job specific orientation on immediate actions and notifications to be taken for loose stools and for identification of skin integrity issues.</p>	<p>June 6, 2014</p> <p>June 6, 2014</p> <p>June 6, 2014</p> <p>June 6, 2014</p>
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F 279	<p>Continued From page 26</p> <p>that was soiled with a mustard colored liquid stool. Additional observations on 05/05/14 at 1:47 PM and 05/08/14 at 7:13 AM revealed Resident #13 had loose watery mustard colored stools.</p> <p>During an interview on 05/08/14 at 4:57 PM Nurse #7 who was familiar with the care for Resident #13 stated she had not been notified that Resident #13 had watery diarrhea stools. Nurse #7 explained that it was her expectation that when a resident had diarrhea the floor nurse would initiate standing orders for medications for diarrhea, and the medications would be given. Nurse #7 added the resident would be further monitored and assessed for continued changes in his bowel pattern and care would be planned for a resident with diarrhea.</p> <p>An interview was conducted on 05/09/14 at 8:52 AM with the Medical Director (MD). The MD stated he was not aware of Resident #13 having persistent watery diarrhea stools and that it was his expectation that nurses communicated the resident 's condition for further orders. The MD further stated Imodium was a standard standing order to treat residents as needed for diarrhea for a short term period, but if the diarrhea were persistent the resident would be assessed for medical conditions or medications that would cause the loose stools. The MD verified the order was given for Imodium in March and it was his expectation medications were given as ordered. The MD confirmed nursing would use the Imodium medications for 2 to 3 days and if the diarrhea continued he would be notified for further assessment, evaluation and/or orders. The MD explained that persistent watery diarrhea loose stools should be resolved within a couple of days and that communication was paramount for</p>	F 279	(cont. from pg. 28) All reports will be submitted to Quality Assurance and Performance Improvement Committee monthly for four months for validation of compliance with update/change as indicated.	June 6, 2014	

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F 279	<p>Continued From page 27</p> <p>continued persistent diarrhea or changes in a resident's condition.</p> <p>An interview was conducted on 05/09/14 at 10:04 AM with the MDS Coordinator (MDSC). The MDSC stated Resident #13 had a care plan for constipation but not for diarrhea. The MDSC added she was not notified of Resident #13 having a problem with diarrhea or loose stools. The MDSC explained if she were notified of the problem area, a care plan would have been initiated. The MDSC confirmed that communication should have been provided through nursing of new orders for diarrhea medications from the MD and addressed during morning staff meetings resulting in the development of a new care plan for diarrhea. The MDSC verified that a one time occurrence of diarrhea would not result in a care plan but a persistent problem of diarrhea would result in a care plan.</p> <p>An interview was conducted on 05/09/14 at 12:59 PM with the Director of Nursing (DON). The DON stated she was aware of Resident #13 having loose stools since his admission to the facility but was not aware of any diagnoses to address any diarrhea or gastrointestinal disease. The DON explained Resident #13 had a diagnosis of diarrhea added in March of 2014 and he had a medication order for Imodium in place on 03/18/14. The DON revealed that it was her expectation that the nurses give the Imodium as ordered for diarrhea episodes; the resident should be monitored and assessed for further loose stools, and communicated to the MD for further assessments, evaluations and orders. The DON added that care plans should have been implemented when the new diagnosis was added</p>	F 279			

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F 279	<p>Continued From page 28 for Resident #13. The DON verified there was no care plan in place for diarrhea.</p> <p>2. Resident #127 was admitted to the facility 4/22/14 with diagnoses which included pernicious anemia, mental disorder, and history of rectal cancer.</p> <p>The nursing admission assessment dated 04/22/14 was reviewed. Under the heading of Head/Face, a sub-heading of Pain Location was noted. In this section "skin Ca (cancer) removed L (left) ear" was documented. In the Body Audit section face, neck, and ears were described as "normal". There was no other notation in the assessment regarding a wound on the resident's left ear. The admission assessment was signed by Nurse #4.</p> <p>A review of Resident #127's medical record revealed an interim care plan dated 04/22/14 and signed by Nurse #4. The wound was not entered onto the interim care plan.</p> <p>An admission Minimum Data Set (MDS) dated 04/28/14 indicated Resident #127's cognition was severely impaired. The MDS specified the resident was understood, understands others and required extensive to limited staff assistance with activities of daily living. The MDS did not note a surgical wound present. A review of care plans initiated with this assessment did not include a plan of care for the ear wound.</p> <p>An observation on 05/06/14 at 8:39 AM revealed an open area on Resident #127's left ear. The area was located at the top of the outer left ear. The area was approximately 1/2 to 3/4 inch in</p>	F 279		
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F 279	<p>Continued From page 29</p> <p>length, dark red in color, without drainage, and indented the top of the ear. An additional observation on 05/07/14 at 10:23 AM revealed the wound was unchanged.</p> <p>An interview was conducted with the Wound Nurse on 05/07/13 at 1:53 PM. During this interview, the Wound Nurse observed the wound on Resident #127's left ear. She stated she had not known of this wound until now. The Wound Nurse explained this wound should have been reported to her so care could be planned to ensure healing without complication.</p> <p>An interview was conducted with Nurse #4 on 05/08/14 at 8:27 AM. He stated he admitted Resident #127 to the facility on 04/22/14. Nurse #4 explained the resident had a skin cancer removed from the left outer ear the morning before being admitted to the facility. He added he did not report this wound to the Wound Nurse. The wound was not entered onto the interim care plan dated 04/22/14.</p> <p>An interview was conducted with the MDS Coordinator #1 on 05/08/14 at 3:15 PM. She stated when gathering MDS information, she does a face to face assessment and did so with Resident #127. The MDS Coordinator stated she did not notice a wound on Resident #127's left ear. She added if the wound had been noted, a care plan would have been initiated.</p> <p>An interview was conducted with the Director of Nursing (DON) on 05/09/14 at 1:38 PM. The DON stated the wound on Resident #127's left ear should have been measured and added to a wound assessment module where it could be followed. The DON emphasized this was more</p>	F 279			

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F 309	Continued From page 31 short term cognitive impairment. The MDS further coded Resident #13 for required extensive staff assistance with bed mobility, transfers, dressing, and toileting, and was always incontinent of bowel and frequently incontinence of bladder. Review of the facility standing orders dated 06/15/12 included medication orders for diarrhea were included in the chart on the resident's admission. The standing orders were to be implemented by writing a telephone order, writing an order on the Medication Administration Record and notifying the physician of the implementation of the standing order. The standing orders specified documentation of findings including but not limited to diarrhea, complaints, pain, bowel sounds and vital signs. The orders indicated give loperamide (medication for diarrhea), begin with 4 milligrams (mg) by mouth initially, then 2 mg by mouth after every loose stool not to exceed 16 mg for 24 hours or until resident is no longer symptomatic, which ever is sooner. Notify the physician if symptoms persist for greater than 24 hours for further orders and notify the family or representative. A review of the bowel report records recorded by nursing assistants for January 2014 indicated Resident #13 had 31 watery liquid stools documented in 19 days with the nurse notified notation, 10 of the 19 days were documented with multiple watery stools. A review of the medication administration records (MAR) dated 01/01/14 through 01/31/14 revealed no orders written on the MAR for anti-diarrhea medications or for any medications given for diarrhea.	F 309	<i>Continued from page 31</i> Audit performed by Director of Health Services or nursing designee utilizing the Data Collection History BM Report from the Electronic Medical Record data base for all residents. Evaluation, intervention, reporting and documentation as indicated for issues identified during audit. Director of Health Services or designee to perform audit of all Admissions/Re-admissions last 30 days to identify any additional residents at risk. Evaluation, intervention, reporting and documentation as indicated for loose stool or skin integrity issues identified during audit. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Nurse Supervisor or designee will pull data from Bowel Elimination Report and 24 hour report tool daily and initiate action and notify physician as indicated. Electronic Medical Record SMART Chart for CNA's automatically sends nurse notified to Nurse when loose stool/watery stool is selected during documentation.	June 6, 2014	June 6, 2014

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F 309	Continued From page 32 A review of the bowel report records recorded by nursing assistants for February 2014 indicated Resident #13 had 32 watery liquid stools documented in 18 days with the nurse notified notation, 11 of the 18 days were documented with multiple watery stools. A review of the MAR dated 02/01/14 through 02/28/14 revealed no orders written on the MAR for anti-diarrhea medications or for any medications given for diarrhea. A review of the bowel report records recorded by nursing assistants for March 2014 indicated Resident #13 had 27 watery liquid stools in 17 days with the nurse notified notation, 7 of the 17 days were documented with multiple watery stools. During the March 16th through the 20th period Resident #13 was noted to have 10 watery liquid stools during that 5 day time frame with the nurse notified notation. A review of the MAR dated 03/01/14 through 03/31/14 revealed an order written on the MAR entered 03/18/14 by an arrow for Imodium 2 mg by mouth every 6 hours as needed for diarrhea with no initials of being given. A review of the bowel report records recorded by nursing assistants for April 2014 indicated Resident #13 had 19 watery liquid stools documented in 15 days with the nurse notified notation, 4 of the 15 days were documented with multiple watery stools. A review of the MAR dated 04/01/14 through 04/30/14 revealed orders written on the MAR for anti-diarrhea medications with no medications given for diarrhea.	F 309	<i>Continued from page 32</i> Nursing Assistants educated to notify nurse of all loose stools via facility report 24 hour report tool as well as reporting of all skin integrity issues to licensed nurse immediately. Licensed Nurses educated to pull from database record of "No BM" and "Nurse Notified" for daily review Nurses educated on immediate update of Interim/Individualized Care plan, notification of MD notification and Skin Integrity Coordinator and initiation of treatment if indicated for any skin integrity issues identified How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance? Education will be provided to new partners upon general and job specific orientation On notification and action required for loose stools and skin integrity issues. All reports will be submitted to Quality Assurance and Performance Improvement Committee monthly for validation of compliance with update/change as indicated.	June 6, 2014	June 6, 2014
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F 309	Continued From page 33 A review of the bowel report records recorded by nursing assistants dated 05/01/14 through 05/08/14 reflected Resident #13 had 3 days with watery liquid stools documented with the nurse notified notation. A review of the MAR dated 05/01/14 through 05/31/14 revealed orders written on the MAR for anti-diarrhea medications with no medications given for diarrhea. A review of the physician's progress notes dated 03/18/14 indicated Resident #13 was seen due to nursing staff request for evaluation regarding complaints of nausea, vomiting and diarrhea. The physician's physical exam indicated Resident #13's abdomen was soft and diffusely tender and nursing staff had reported vomiting and diarrhea. The physician's plan indicated adding the medication Imodium 2 mg by mouth every 6 hours for diarrhea, monitor closely and notify the physician immediately for any changes in his condition. A review of the physician orders dated 03/18/14 revealed an order written for Imodium (medication for diarrhea) 2 mg by mouth every 6 hours as needed for diarrhea. Review of nurse's notes from March 18, 2014 through May 2014 revealed 3 nurses notes addressing watery liquid stools. Nurse's notes were as follows: 1) The nurse note dated 03/19/14 at 12:21 AM Nursing assistant (NA) reported resident with large soft loose stool this evening, with no complaints of cramping or distress voiced, no further complaints of nausea and will continue to	F 309	(continued from page 33) Nursing Administration and Skin Integrity Coordinator will monitor newly admitted residents with skin integrity issues weekly for four weeks, then monthly for four months. Results of these finding to be reported to QAPI committee monthly for four months.	June 6, 2014

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F 309	<p>Continued From page 34 observe.</p> <p>2) The nurse note date 03/19/14 at 2:34 PM revealed resident was administered Imodium per standing orders for watery stool.</p> <p>3) The nurse note dated 04/12/14 at 11:03 PM revealed Resident #13 had large loose bowel movement this evening, no complaints of cramping, distress or nausea and vomiting. Noted one episode only and continue to monitor for loose stools.</p> <p>A review of the care plans revealed care plans last reviewed dated 03/24/14 for constipation, history of weight loss and nurse assistant care interventions. Interventions included were lactaid milk due to intolerance of milk, therapeutic diet and nutritional supplements as ordered by the physician, and assistive dietary devices with dining assistance by staff. No care plan was in place for diarrhea to review.</p> <p>During an observation on 05/05/14 at 1:47 PM Nurse Assistant (NA) #6 was observed providing incontinent care to Resident #13. Resident #13 was observed to be restless, turning and wiggling and complaints of pain to his bottom. Resident was noted wearing a brief that was soiled with a liquid stool. NA #6 provided appropriate incontinent care. The residents' bottom was observed to have no breakdown or irritation at this time. NA #6 stated that Resident #13 frequently had watery stools.</p> <p>During an observation on 05/07/14 at 1:46 PM NA #6 had assisted Resident #13 to the toilet. A loose, unformed stool was observed in the toilet at this time.</p> <p>During an observation on 05/08/14 at 7:13 AM</p>	F 309			

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F 309	<p>Continued From page 35</p> <p>NA#7 was observed completing care for Resident #13. NA #7 stated the bowel movement was very loose. The brief was observed containing a loose and unformed stool.</p> <p>During an interview on 05/08/14 at 1:46 PM NA #6 stated Resident #13 frequently had watery stools which she documented in the bowel records each time. NA #6 further stated she had been taking care of Resident #13 for the past 3 months and he had loose stools like this frequently and she had reported the loose stools to the nurses.</p> <p>During an interview on 05/08/14 at 4:57 PM Nurse #7 who was familiar with the care for Resident #13 stated she had not been notified that Resident #13 had watery diarrhea stools. Nurse #7 further stated that it was her expectation that when a resident had diarrhea the NAs would notify their floor nurses. Nurse #7 added the floor nurse would initiate standing orders for medications for diarrhea, the medications would be give. Nurse #7 further added the resident would be further monitored and assessed for continued changes in his bowel pattern. Nurse #7 reviewed the MARs and confirmed there was a physician's order for Imodium was added on 03/18/14 for Imodium. Nurse #7 also confirmed the Imodium had not been administered to Resident #13 for diarrhea since the order was written.</p> <p>During an interview on 05/08/14 at 5:06 PM Nurse #6 stated she was the floor nurse today but was normally the nurse supervisor. Nurse #6 added she had not been notified that Resident #13 had watery diarrhea stools. Nurse #6 revealed the floor nurse normally would handle</p>	F 309		

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F 309	<p>Continued From page 36</p> <p>giving medications for diarrhea when it was reported. Nurse #6 explained it was her expectations were for the NA to report watery diarrhea stools to the nurses and the nurse would provide the intervention to handle the diarrhea which was to give the anti-diarrhea medication.</p> <p>An interview was conducted on 05/09/14 at 8:52 AM with the Medical Director (MD). The MD stated he was not aware of Resident #13 having persistent watery diarrhea stools and that it was his expectation that nurses communicated the resident's condition for further orders. The MD further stated Imodium was a standard standing order to treat residents as needed for diarrhea for a short term period, but if the diarrhea were persistent the resident would be assessed for medical conditions or medications that would cause the loose stools. The MD verified the order was given for Imodium in March 2014 and it was his expectation medications were given as ordered. The MD confirmed nursing would use the Imodium medications for 2 to 3 days and if the diarrhea continued he would be notified for further assessment, evaluation and/or orders. The MD explained that persistent watery diarrhea loose stools should be resolved within a couple of days and that communication was paramount for continued persistent diarrhea or changes in a resident's condition.</p> <p>An interview was conducted on 05/09/14 at 10:04 AM with the MDS Coordinator (MDSC). The MDSC stated Resident #13 had a care plan for constipation but not for diarrhea. The MDSC added she was not notified of Resident #13 having a problem with diarrhea or loose stools. The MDSC explained if she were notified of the problem area, a care plan would have been</p>	F 309			

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F 309	<p>Continued From page 37</p> <p>initiated. The MDSC confirmed that communication should have been provided through nursing of new orders for diarrhea medications from the MD and addressed during morning staff meetings resulting in the development of a new care plan for diarrhea. The MDSC verified that a one time occurrence of diarrhea would not result in a care plan but a persistent problem of diarrhea would result in a care plan.</p> <p>An interview was conducted with Nurse #4 on 05/09/14 at 11:20 AM. Nurse #4 stated he was the nurse supervisor on the Bravo and Charley Halls during the time Resident #13 was a resident. Nurse #4 explained it was standard nursing procedure that NAs notified the floor nurses and or the nurse supervisors of residents with watery loose stools. Nurse #4 added the nurses initiated standing orders for anti-diarrhea medications, and assessed, documented and notified the physician of the resident's loose watery stools for further evaluations and orders. Nurse #4 confirmed he was not aware of Resident #13 having problems with diarrhea.</p> <p>An interview was conducted on 05/09/14 at 12:59 PM with the Director of Nursing (DON). The DON stated she was aware of Resident #13 having loose stools since his admission to the facility but was not aware of any diagnoses to address any diarrhea or gastrointestinal disease. The DON explained Resident #13 had a diagnosis of diarrhea added in March of 2014 and he had a medication order for Imodium in place on 03/18/14. The DON revealed it was her expectation the nurses give the Imodium as ordered for diarrhea episodes, the resident should be monitored and assessed for further</p>	F 309		

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F 309	<p>Continued From page 38</p> <p>loose stools, and communicated to the MD for further assessments, evaluations, and orders. The DON added care plans should have been implemented when the new diagnosis was added for Resident #13. The DON reviewed the MAR and stated it was not documented that Resident #13 received Imodium for diarrhea at any time during the months of January through May of 2014, except one time as noted in the nurse's notes on 03/19/14. The DON confirmed that standing orders should have been initiated for watery diarrhea stools and that MD should have been notified for further assessment. The DON further confirmed that the Imodium was not given as ordered and should have been given after each watery stool. The DON verified there was no care plan in place for diarrhea.</p> <p>2. Resident #127 was admitted to the facility 04/22/14 with diagnoses which included pernicious anemia, mental disorder, and history of rectal cancer.</p> <p>The nursing admission assessment dated 04/22/14 was reviewed. Under the heading of Head/Face, a sub-heading of Pain Location was noted. In this section "skin Ca (cancer) removed L (left) ear" was documented. In the Body Audit section, face, neck, and ears were described as "normal". There was no other notation in the assessment regarding a wound on the resident's left ear. The admission assessment was signed by Nurse #4.</p> <p>A review of Resident #127's medical record revealed an interim care plan dated 04/22/14. There was no plan of care regarding a wound on</p>	F 309			

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F 309	<p>Continued From page 39 the resident's left ear.</p> <p>A review was conducted of a body audit form dated 04/26/14. The form was signed by Nurse #2. The section designated face, neck and ears contained a mark by "discoloration". Continued medical record review revealed a nursing note dated 04/26/14 written by Nurse #2. The note did not describe "discoloration" as designated on the body audit.</p> <p>An admission Minimum Data Set (MDS) dated 04/28/14 indicated Resident #127's cognition was severely impaired. The MDS specified the resident was understood, understands others and required extensive to limited staff assistance with activities of daily living. The MDS did not note a surgical wound present.</p> <p>An observation on 05/06/14 at 8:39 AM revealed an open area on Resident #127's left outer ear. The area was approximately ½ inch in length, dark red in color, without drainage, and indented the top of the ear. An additional observation on 05/07/14 at 10:23 AM revealed the wound was unchanged.</p> <p>An interview was conducted with Nurse #2 on 05/07/14 at 12:55 PM. Nurse #2 stated the discoloration she had noted on the body audit dated 04/26/14 was related to a redness she observed on Resident #127's face and neck. She stated it area looked like the resident had been out in the sun. Nurse #2 added she did not notice a wound on the resident's left outer ear.</p> <p>An interview was conducted with the Wound Nurse on 05/07/13 at 1:53 PM. During this interview, the Wound Nurse observed the wound</p>	F 309		

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F 309	<p>Continued From page 40</p> <p>on Resident #127's left outer ear. She stated she had not known of this wound until now. The Wound Nurse explained this wound should have been reported to her so it could be monitored to ensure healing without complication.</p> <p>An interview was conducted with Nurse Aide (NA) #2 on 05/07/14 at 1:55 PM. NA #2 stated she had observed the wound on the left ear since Resident #127 was admitted to the facility. NA #2 added she had reported the wound to a nurse but was unable to recall which nurse.</p> <p>An interview was conducted with Nurse #4 on 05/08/14 at 8:27 AM. He stated he admitted Resident #127 to the facility on 04/22/14. Nurse #4 explained the resident had a skin cancer removed from the left outer ear on the morning of 04/22/14 before being admitted to the facility. He stated there were no physician's orders referring to the ear wound. Nurse #4 added he did not report this wound to the Wound Nurse but he should have. He stated the admission occurred late on a Friday afternoon. Nurse #4 acknowledged the Wound Nurse should have known about the wound. When asked how he notified the Wound Nurse of skin issues, he replied he reported verbally.</p> <p>An interview was conducted with MDS Coordinator (MDSC) on 05/08/14 at 3:15 PM. She stated when gathering MDS information, she does a face to face assessment and did so with Resident #127. MDSC stated she did not notice a wound on Resident #127's left ear. She added if the wound had been noted, a care plan would have been initiated and the wound added to the wound assessment module. She explained wounds in the wound assessment module were</p>	F 309			

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F 309	Continued From page 41 followed in weekly wound care meetings. An interview was conducted with the Director of Nursing (DON) on 05/09/14 at 1:38 PM. The DON stated the wound on Resident #127's left outer ear should have been measured and added to a wound assessment module where it could be followed. The DON emphasized this was more important since the skin cancer had been removed on the morning of 04/22/14 before admission to the facility. She stated the wound should have been entered on a care plan so it could be assessed and monitored.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and medical record review, the facility failed to provide oral care for 3 of 3 residents (Resident #119, #106, and #72) requiring extensive or total assistance for activities of daily living. The findings included: 1. Resident #119 was admitted to the facility on 03/28/14 with diagnoses which included muscle weakness, chronic kidney disease, and glaucoma. The most recent Minimum Data Set	F 312	What corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident #119 Plan of care and CNA ADL/Care guide updated to include CNA assistance with oral hygiene during AM and PM care Resident #106 Plan of care and CNA ADL/Care guide updated to include CNA assistance with oral hygiene during AM and PM care Resident #72 Plan of care and CNA ADL/Care guide updated to include CNA assistance with oral hygiene during AM and PM care	May 30, 2014 May 30, 2014 May 30, 2014	

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F 312	<p>Continued From page 42</p> <p>(MDS), an admission assessment dated 04/04/14, indicated the resident was cognitively intact and usually able to understand and usually able to make himself understood. The MDS also indicated Resident #119 needed extensive assistance with personal hygiene with the assistance of two or more persons. The MDS did not indicate the resident resisted care.</p> <p>Interview with Resident #119 on 05/05/14 at 3:22 PM revealed staff helped him to brush his teeth about once a week but not more often. Resident #119 stated he had found a toothbrush in his bathroom and had started to try to brush his own teeth occasionally, but wasn't able to clean his teeth very thoroughly without help.</p> <p>Observation of Resident #119 on 05/05/14 at 3:29 PM revealed pieces of food and white and brown debris visible on all teeth, with film covering top of teeth at gumline. Observation of toothbrush revealed toothbrush was dry, in plastic container in bathroom next to sink.</p> <p>Interview with Nurse Aide (NA) #2 on 05/07/14 at 10:48 AM revealed residents were to receive oral care assistance in the morning after waking up, after lunch, and again in the evening before bed. NA #2 stated the data system used by NAs to document oral care included information showing personal hygiene was attempted and level of assistance required but did not show when resident refused personal hygiene care or parts of hygiene care. NA #2 stated as a result, if any attempt of assistance with personal hygiene was made by a nurse aide, the data would show personal hygiene assistance was provided that day for the resident, even if the task wasn't completed.</p>	F 312	<p><i>Continued from page 42</i></p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Audit to be conducted by Director of Health Services or designee for all Residents who are identified on the Minimum Data Set as dependent for ADL's to ensure that necessary care and services for oral hygiene addressed on plan of care.</p> <p>Director of Health Services or designated licensed nurse to perform assessment or oral hygiene for 2 residents who are dependent with ADL's per unit weekly for four weeks and monthly for four months and will provide immediate education to C.N.A. if unsatisfactory oral hygiene found.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>CNA staff education on proper AM and PM oral care.</p> <p>How will the corrective action be monitored to assure that the deficient</p>	June 6, 2014	June 6, 2014	June 6, 2014

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F 312	Continued From page 43 Interview with Nurse #8 on 05/07/14 at 2:05 PM revealed her expectation that all residents who needed assistance with tooth brushing would receive that assistance in the morning when they got up and again after each meal. Nurse #8 stated nurse aides were to check independent residents' teeth for cleanliness after each meal when residents were able to brush their own teeth, and provide assistance when needed. Observation of Resident #119 on 05/07/14 at 3:45 PM revealed the resident's teeth were covered with food debris, had food between teeth, and a film covering Resident #119's tongue. A foul odor was also detected coming from Resident #119's mouth during the observation. Resident #119 stated his teeth hadn't been brushed in a week or longer. Observation of Resident #119's bathroom revealed a dry toothbrush and dry sink. Interview with NA #8 on 05/07/14 at 3:50 PM revealed even though she was assigned to Resident #119, all staff completed care tasks for all residents and she did not know who had completed oral care for Resident #119 that day. NA #8 stated she had not completed oral care for Resident #119 any time that day. When observing Resident #119's mouth and teeth, NA #8 stated Resident #119's teeth were very dirty, had lots of food between his teeth, had a foul odor to his mouth, and did not appear to have been brushed at least all day. During the observation, NA #8 assisted Resident #119 with oral care and Resident #119 stated he had not received assistance with oral care in at least a week. Observation of Resident #119 on 05/08/14 at 3:23	F 312	<i>Continued from page 43</i> Clinical Competency Coordinator or designee to observe oral hygiene for 2 C.N.A.'s per unit weekly for four weeks and monthly for four months and will provide immediate education to C.N.A. if unsatisfactory oral hygiene found. Education will be provided to new partners upon general and job specific orientation On providing appropriate oral care during a.m. and p.m. care. All reports will be submitted to Quality Assurance and Performance Improvement Committee monthly for four months for validation of compliance with update/change as indicated	June 6, 2014 June 6, 2014 June 6, 2014

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F 312	<p>Continued From page 44</p> <p>PM revealed small amount of food debris in teeth (much less than previous observations). Resident #119 stated staff had brushed his teeth that morning and it was the first morning his teeth had been brushed in over a week. Observation of Resident #119's bathroom revealed a moist toothbrush and water spots in sink.</p> <p>Review of the staffing sheet for 05/08/14 revealed nurse aide #3 was assigned to provide care for Resident #119.</p> <p>Interview with NA #3 on 05/08/14 at 3:45 pm revealed nurse aides on the hall where Resident #119 lived all worked together to provide morning care for all residents, regardless of specific resident assignments. NA #3 stated he couldn't remember the last time he had provided oral care assistance for Resident #119. NA #3 stated he wasn't aware of the level of assistance Resident #119 required with oral care.</p> <p>Observation of Resident #119 on 05/09/14 at 9:45 AM revealed food debris on all teeth. Resident #119 stated his teeth had not been brushed yet. Observation of Resident #119's bathroom revealed dry toothbrush and dry sink.</p> <p>Interview with director of nursing (DON) on 05/09/14 at 12:44 PM revealed her expectation that residents who require assistance with oral care will receive assistance in the morning, in the evening, and after meals as needed. The DON stated toothbrushing has not been a priority for nurse aides in the facility because they had been so focused on meals and toileting and had lost track of oral care.</p>	F 312		

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F 312	<p>Continued From page 45</p> <p>2. Resident #106 was admitted to the facility on 02/10/14 with diagnoses which included chronic kidney disease, muscle weakness, and lack of coordination. The most recent Minimum Data Set (MDS), an admission assessment dated 04/17/14, indicated the resident was cognitively intact, able to understand and to be understood. The MDS also indicated Resident #106 needed extensive assistance with personal hygiene with the assistance of two or more persons. The MDS did not indicate the resident resisted care.</p> <p>Interview with Resident #106 on 05/05/14 at 3:01 PM revealed Resident #106 did not receive assistance with oral care and he brushed his teeth the best he could when he remembered. Resident #106 stated no nurse aide or nurse had assisted him with oral care or checked his teeth in over a month. During the interview with Resident #106 on 05/05/14 at 3:01 PM, the resident opened his mouth, revealing food debris on upper and lower teeth, a film on tongue, and red and swollen gums. Observation of Resident #106's bathroom revealed a dry toothbrush and sink.</p> <p>Review of nursing notes in Resident #106's medical record revealed no documentation of refusal of care after night of facility admission on 02/10/14.</p> <p>Interview with Nurse Aide (NA) #2 on 05/07/14 at 10:48 AM revealed residents were to receive oral care assistance in the morning after waking up, after lunch, and again in the evening before bed. NA #2 stated the data system used by NAs to document oral care included information showing personal hygiene was attempted and level of assistance required but did not show when</p>	F 312		

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F 312	<p>Continued From page 46</p> <p>resident refused personal hygiene care or parts of hygiene care. NA #2 stated as a result, if any attempt of assistance with personal hygiene was made by a nurse aide, the data would show personal hygiene assistance was provided that day for the resident, even if the task wasn't completed.</p> <p>Interview with Nurse #8 on 05/07/14 at 2:05 PM revealed she expected all residents who needed assistance with toothbrushing would receive that assistance in the morning when they got up and again after each meal. Nurse #8 stated nurse aides were to check independent residents' teeth for cleanliness after each meal when residents were able to brush their own teeth, and provide assistance when needed.</p> <p>Interview with NA #3 on 05/08/14 at 3:45 pm revealed nurse aides on the hall where Resident #119 lived all worked together to provide morning care for all residents, regardless of specific resident assignments. NA #3 stated he couldn't remember the last time he had provided oral care assistance for Resident #106. NA #3 stated he wasn't aware of the level of assistance Resident #106 required with oral care.</p> <p>Observation of resident #106 on 05/08/14 at 4:40 PM revealed food debris on and between upper and lower teeth, with foul odor detected from mouth. Resident was in dining room visiting with a friend during observation.</p> <p>Interview with director of nursing (DON) on 05/09/14 at 12:44 PM revealed her expectation that residents who require assistance with oral care will receive assistance in the morning, in the evening, and after meals as needed. The DON</p>	F 312			

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F 312	<p>Continued From page 47</p> <p>stated toothbrushing had not been a priority for nurse aides in the facility because they had been so focused on meals and toileting and had lost track of oral care. The DON also stated she had noticed Resident #106 having a foul odor from his mouth and needing oral care.</p> <p>3. Resident #72 was admitted to the facility on 04/23/14 with diagnosis which included depressive disorder, dementia, general osteoarthritis, generalized muscle weakness and lack of coordination.</p> <p>The most recent Minimum Data Set (MDS) dated 04/30/14 specified the resident was moderately impaired cognitively for daily decision making skills, did not refuse care and was totally dependent on staff for personal hygiene.</p> <p>A review of the care plan dated 04/30/14 revealed Resident #72 had a physical functioning deficit related to self care impairment with an intervention for staff to provide daily grooming, oral and skin care. The care plan identified a goal for the resident would have personal hygiene met daily which included oral care.</p> <p>On 05/06/14 at 09:41 AM Resident #72 was interviewed and asked if staff helped him to clean his teeth and he answered, "No." Resident #72 was asked if he brushes his own teeth and he answered "No." Resident #72's teeth were observed and revealed they had a thick accumulation of white matter along the gum line</p>	F 312		

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F 312	<p>Continued From page 48</p> <p>of his top and bottom teeth. His teeth were visibly dirty.</p> <p>On 05/07/14 at 9:16 AM Resident #72 was observed in bed watching television. His teeth were observed and noted to have white substance accumulating along the gum line and coating between the teeth of the upper and lower teeth. When asked if he had his teeth brushed this morning and he responded, "No."</p> <p>An interview was conducted on 05/07/14 at 1:36 PM with the family member. The family member stated she visited a couple times a week. She added the resident did not get his teeth brushed everyday. She explained on the days she visited, she would brush his teeth and could tell by the amount of substance between his teeth and gums that he hadn't had his teeth brushed. The family member added Resident #72 had told her he hadn't had his teeth brushed. The family member revealed she had discussed mouth care with the nurses and aides about having his teeth brushed daily.</p> <p>On 05/08/14 at 8:58 AM Resident #72 was observed in his reclining chair in his room. The resident was noted to have a white substance in between all of his teeth at the gum line of the upper and lower teeth. The resident's tooth brush and oral mouth care tray were observed in the bathroom on the sink and were visibly dry.</p> <p>An observation of Resident #72 was made on 05/08/14 at 10:41 AM in his recliner in his room. Resident #72 was asked if he had his teeth brushed this morning and he responded, "No." The resident was noted to have a white substance in between all of his teeth at the gum</p>	F 312		

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F 312	<p>Continued From page 49</p> <p>line of the upper and lower teeth. The resident's tooth brush and oral mouth care tray were observed in the bathroom on the sink and were visibly dry.</p> <p>An observation of Resident #72 was made on 05/08/14 at 2:55 PM. The resident remained in his recliner watching televising in the living room. Resident #72 again stated he had not had his teeth brushed today. The resident was noted to have a white substance in between all of his teeth at the gum line of the upper and lower teeth. The resident's tooth brush and oral mouth care tray were observed in the bathroom on the sink and were visibly dry.</p> <p>An interview was conducted with Nurse #7 on 05/08/14 at 2:55 PM. Nurse #7 observed Resident #72's teeth and confirmed she observed the white substance on all of his teeth both top and bottom. Nurse #7 stated she was not aware he hadn't had his teeth brushed. Nurse #7 stated it was her expectation for nurse aides (NA) to provide all activities of daily living (ADL) which included teeth brushing and personal hygiene for all residents who were dependent for care.</p> <p>An interview was conducted with NA #7 on 05/08/14 at 3:05 PM. NA #7 revealed she did not brush Resident #72's teeth today. NA #7 explained she did not have time before she was assigned to a different hallway at lunch time. NA #7 revealed she knew Resident #72 was dependent for all his ADLs and she needed to brush his teeth.</p> <p>An interview was conducted with Nurse #6 on 05/08/14 at 5:17 PM. Nurse #6 stated she was not aware that Resident #72 hadn't had his teeth</p>	F 312		

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F 312	Continued From page 50 brushed. Nurse #6 stated it was her expectation for NAs to provide all activities of daily living (ADL) which included teeth brushing and personal hygiene for all residents who were dependent for care. Nurse #6 added NAs needed to provide teeth brushing after meals or at least every shift for all residents who were dependent for care or needing assistance. An interview was conducted with the Director of Nursing on 05/09/14 at 12:59 PM revealed it was her expectation oral care be provided daily for all residents requiring assistance or dependent for activities of daily living.	F 312	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to properly store frozen foods in 1 of 2 nourishment rooms, to dispose of resident-purchased food past manufacturer use-by dates in 1 of 2 nourishment rooms, to properly clean 3 of 5 kitchen areas, to properly clean an ice scoop holder in 1 of 5 kitchen areas, to provide clean containers for	F 371	What corrective action will be accomplished for the residents found to have been affected by the deficient practice? Thermometers placed in the freezers in both nourishment rooms May 5, 2015 Food disposed of and Maintenance notified Sign posted "out of order" May 5, 2015 Cleaned/replaced affected containers May 5, 2015 Sandwich and Tarter Sauce disposed of and fresh items provided by Dietary at appropriate temperatures. Dietary Aide # 1 was educated immediately on proper temperatures May 5, 2015 All areas and equipment identified for deep cleaning were cleaned by Dietary Manager May 5, 2015

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<p>F 371</p>	<p>Continued From page 51</p> <p>food storage, and to serve a cold potentially hazardous food item at a temperature of 41 degrees Fahrenheit or below in 1 of 5 kitchen areas.</p> <p>Findings included:</p> <p>1. An observation on 05/07/14 at 10:58 AM of the nourishment room used for Bravo and Charlie units revealed a Daily Freezer/Refrigerator Temperature Log affixed to the door of the refrigerator/freezer. Printed instructions on this form directed a designated food service employee was to record the time, air temperature and their initials in the morning and the afternoon and "It is not necessary to check temperatures of food products but touch several products to be sure they are cold and frozen items are solid to the touch."</p> <p>An observation on 05/07/14 at 10:58 AM of the nourishment room used for Bravo and Charlie units revealed in the freezer 21 foam containers, each 4 ounces, of an orange cream flavored fortified food. All 21 containers had the following manufacturer's printed instructions: "store frozen, serve as ice cream or pudding consistency when thawed, use within 5 days of thawing, for creamy consistency thaw 4 hours prior to eating." Three containers were observed stored in the door of the freezer and 18 containers were observed stored on the lowest level, in the middle and back of the freezer. Pressing the sides of all the containers revealed the product to be soft. Also observed in the door of the freezer were 3 pint-sized containers partially full of ice cream with resident names and on the lowest level in the back corner were another 2 pint-sized containers partially full of ice cream with resident names. All</p>	<p>F 371</p> <p><i>Continued from page 51</i></p> <p>All areas and equipment identified for deep cleaning were cleaned by Dietary Manager</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Dietary Manager, provided supervisory rounds to other neighborhoods without identification of any other residents at risk</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>Nourishment rooms and kitchenettes to be checked by Dietary Aides daily to record refrigerator and freezer temperatures, to check labeling and dating of food items and to check cleanliness of floors and storage containers.</p> <p>Dietary supervisors to check nourishment room, kitchenettes and main kitchen on compliance rounds for clean storage containers, clean ice scoops, properly dated and labeled food items, appropriate refrigerator and freezer temperatures, grease build-up near steamer and deep fryer and general dirt or grease on floors of kitchenette and main kitchen. This will be checked three times weekly for four weeks, then weekly for four months.</p>	<p>May 5, 2014</p> <p>May 5, 2014</p> <p>June 6 2014</p> <p>June 6 2014</p>
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F 371	<p>Continued From page 52</p> <p>5 pints of ice cream were soft when the cartons were squeezed.</p> <p>An interview on 05/07/14 at 11:41 AM with the Registered Dietician revealed the fortified food item came from the main kitchen freezer to the nourishment room freezers and were to remain frozen until removed, then they would thaw during a meal at the dining table. She stated whoever was checking temperatures for the refrigerators should also have been checking to make sure the freezer was working. She stated there was no column on the temperature log for freezer temperatures, there was no thermometer for the freezer but items in it should have been frozen solid.</p> <p>An interview on 05/09/14 at 10:05 AM with Dietary Manager revealed Maintenance staff checked temperatures on refrigerators and the dietary aides were expected to back them up. He stated the foam containers of fortified food were stocked like regular nourishment items at 12:00 noon, 8 containers at a time along with containers of ice cream. He stated the fortified food was to remain frozen until used.</p> <p>2. An observation dated 05/07/14 at 10:12 AM of the nourishment room for Alpha and Delta units revealed the following:</p> <p>a. In an upper cabinet was found a box of frosted shredded wheat cereal, labeled with a resident name and room number. The inner bag holding the cereal was partially unrolled at the opening and was approximately 1/4th full. Printed on the box was a manufacturer "best if used by" date of 02/27/14.</p>	F 371	<p><i>Continued from page 52</i></p> <p>Staff educated that freezer or refrigerator temperatures out of the safe range are to be reported to Maintenance and Certified Dietary Manager immediately and food discarded</p> <p>Dietary Manager to adjust daily and weekly cleaning schedules to include cleaning of grease build-up around steamer and deep-fryer daily, bringing storage containers from nourishment rooms to kitchen for thorough cleaning weekly, cleaning of kitchenette floors daily.</p> <p>How will the corrective action be monitored and assured that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Education will be provided to new partners upon general and job specific orientation on keeping floors and storage containers clean, monitoring and reporting safe temperatures in refrigerators and freezers, ensuring all food temperatures are checked at time of service/plating, including sandwiches and sauces.</p>	<p>June 6, 2014</p> <p>June 6, 2014</p> <p>June 6, 2014</p>

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F 371	<p>Continued From page 53</p> <p>b. In a lower cabinet were found various cans of soup labeled with another resident's name and room number. 1 can of ready-to-eat creamy broccoli soup had a printed manufacturer "recommend use by" date of 02/25/14 and another 3 cans with the date of 03/26/14. 1 can of ready-to-eat creamy chicken soup had a date of 03/06/14.</p> <p>c. In a lower cabinet was found a box of instant oatmeal containing 9 single serving packets of various flavors. Printed on the box was the manufacturer "best if used before" date of 02/12/14.</p> <p>An interview on 05/07/14 at 10:40 AM with the Registered Dietician revealed nursing staff were responsible for resident-purchased food storage. She stated the bag of cereal should not have been left open and it should have been removed by nursing when the resident passed away. She stated ready-to-eat food purchased by residents or their family with manufacturer dates should be treated no differently than ready-to-eat food purchased by the facility for resident meals, with all foods being consumed or discarded before the date printed on the container.</p> <p>An interview on 05/09/14 at 10:05 AM with the Dietary Manager revealed dietary aides were expected to monitor all food items stored in nourishment rooms, including those purchased by residents or their family, for proper storage, labeling and food items are within expiration dates.</p> <p>3. Observation of unit kitchenettes at unit dining areas (where resident meals were plated) and the main kitchen (where food was stored and</p>	F 371	<p>cont. from page 54</p> <p>Dietitian to observe plating/serving of food in each nursing unit weekly for appropriate checking of temperatures, including sandwiches. Immediate education to be provided to staff member if out of compliance.</p> <p>Reports from Dietary Supervisors, Dietary Manager and Dietitian to be reviewed by QAPI committee monthly for four months.</p>	<p>June 6, 2014</p> <p>June 6, 2014</p>

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F 371	<p>Continued From page 54 prepared for the entire facility) revealed the following:</p> <p>a. On 05/08/14 at 11:53 AM, observation of the Alpha Unit kitchenette revealed approximately 6 inch wide strip of dirt build-up on the floor, along cabinet baseboards and along the length of the steam table. Food debris was noted along the left side of steam table.</p> <p>b. On 05/09/14 at 9:40 AM, observation of the main kitchen revealed accumulation of grease on the side of the steamer unit and on the tile floor in the vicinity of a small metal table located between the steamer unit and the deep fryer.</p> <p>c. On 05/09/14 at 9:48 AM, observation of the main kitchen with the Dietary Manager revealed a large plastic container holding extra parts for a mixer and food processor, placed on a lower metal shelf under a food preparation counter. On the lid and inside the container was observed debris and crumbs.</p> <p>d. On 05/09/14 at 9:48 AM, observation of the main kitchen with the Dietary Manager revealed an approximate 6 inch wide dirt build-up along the length of a 2 compartment sink next to the meat slicer.</p> <p>An Interview on 05/09/14 at 9:40 AM with the Dietary Manager revealed kitchen staff had access to a degreaser cleaner and the area surrounding the deep fryer was on a weekly cleaning schedule. Further interview with the Dietary Manager on 05/09/14 at 9:48 AM revealed the lid and container holding extra parts for a mixer and food processor should have been clean inside and out. Further interview with the</p>	F 371			

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F 371	<p>Continued From page 55</p> <p>Dietary Manager on 05/09/14 at 10:05 AM revealed dietary aides assigned to unit kitchenettes were responsible for cleaning. He stated everything stored in cabinets in dirty containers were to be swapped out with clean containers and cabinet shelving wiped down and this responsibility was noted on their cleaning list. The Dietary Manager stated Housekeeping staff on the night shift were responsible for mopping the unit kitchenette floors each day and the floor technician would deep clean the floors in the unit kitchenettes and main kitchen once a month. He stated floor technicians should have been using their machines to perform the floor deep cleaning.</p> <p>4. An observation was conducted of staff obtaining food temperatures in the Charlie Hall kitchen on 05/09/14 at 12:07 PM. The temperatures of the foods placed on the steam table were obtained by Dietary Aide (DA) #1. At 12:20 PM another DA from the kitchen delivered a wrapped pimento cheese sandwich to the Charlie Hall refrigerator.</p> <p>At 12:48 PM DA #1 was observed removing the pimento cheese sandwich from the refrigerator. The sandwich was unwrapped and placed on a plate with the intent of handing the plate to the server to be given to a resident. DA #1 did not obtain the temperature of the sandwich when it was delivered to the kitchen or before plating. In an interview at that time, DA #1 stated she did not make the sandwich and does not obtain temperatures of any sandwiches brought over from the kitchen. DA #1 was observed obtaining the temperature of the pimento cheese sandwich by inserting a thermometer straight down into the bread. The temperature reading was 66 degrees</p>	F 371		

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F 371	<p>Continued From page 56</p> <p>Fahrenheit. DA #1 stated she did not make the pimento cheese sandwich and was unaware she should obtain the temperature of cold sandwiches that come from the kitchen.</p> <p>An interview with the Dietary Manger was conducted 05/09/14 at 1:19 PM. He stated all foods, cold or hot, had temperatures obtained before they left the kitchen and again before being served in the neighborhood kitchens. The expected temperature of cold foods was 41 degrees Fahrenheit or below and should be maintained when served from the tray line.</p> <p>5. An observation of the Charlie Hall neighborhood kitchen was conducted 05/07/14 at 3:39 PM with the Registered Dietician (RD). Five 2 quart clear plastic containers were observed in a cabinet. The containers held raisin bran, corn flakes, and rice cereals, thickener, and brown sugar. The containers were observed with finger prints and smudges on the plastic and they were sticky to the touch. The RD checked the cleaning schedule for this kitchen. The containers were not listed for cleaning. The RD stated the containers should be kept clean and without grime.</p> <p>Further observation at this time revealed a holder for an ice scoop mounted on the wall next to the ice machine. An ice scoop was observed in holder at this time and the scoop rested on the bottom of the holder. The inside of the holder contained a black substance observed around the seams of the bottom of the container. The RD checked the cleaning schedule and did not find the ice scoop or holder on the schedule. The RD stated the ice scoop holder should be clean and without discoloration.</p>	F 371		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 57 An interview with Dietary Aide (DA) #2 was conducted on 05/07/14 at 3:40 PM. He stated he was the evening server for the Charlie Hall kitchen. DA #2 explained he was unaware of the condition of the cereal containers or the ice scoop holder. He added the nurse aides on the hall used the ice scoop to obtain ice for the residents. An interview was conducted with the Dietary Manager (DM) on 05/09/14 at 10:05 AM. He stated the dietary aide assigned to that kitchen was in charge of ensuring the kitchen contents were kept clean. If containers were soiled, they should be changed for clean ones. The DM stated the ice scoops and holders should be taken to the kitchen weekly to run through the dish cleaning machine. He added the ice scoop holder should be checked daily to ensure it was always clean.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	What corrective action will be accomplished for the residents found to have been affected by the deficient practice? Nurse #2 educated on appropriate drying time for glucometers following cleaning with germicidal wipes	May 9, 2014	

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F 441	Continued From page 58 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to disinfect blood glucose meters (glucometers) according to facility policy and the manufacturer's instructions during 1 of 1 observations of a glucometer being disinfected. The findings included: A facility policy entitled Blood Glucose Testing Devices dated September 2012 specified in part to disinfect the glucometers with a bleach germicidal wipe and the standardized cleaning and disinfecting procedures would be utilized to promote compliance to manufacturer and CDC	F 441	<i>Continued from page 58</i> How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Medication observation on all units performed by Registered Nurses with additional nurse practice of glucometer cleaning, no further risks were identified. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance? Manufacturers Instructions for glucometer cleaning to be posted at each occupied nursing station and reviewed with licensed nursing staff. Clinical Competency Coordinator or designated licensed nurse will monitor glucometer cleaning for two residents on each unit twice weekly for four weeks, then weekly for four weeks then monthly for four months. Immediate training will be provided to any nurse not following manufacturer's instructions for adequate cleaning and trying times. Education will be provided to new partners upon general and job specific orientation on glucometer cleaning and drying.	May 9, 2014 June 6, 2014 June 6, 2014

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F 441	<p>Continued From page 59</p> <p>guidelines. Glucometer blood sugar monitoring devices would be cleaned and disinfected before and after each resident use.</p> <p>A review of the Instructions provided by the manufacturer of the germicidal disposable wipe utilized by the facility was conducted. The directions specified to accomplish disinfection of a hard surface the treated surface must remain visibly wet. Use enough wipes for treated surface to remain visibly wet for 3 minutes then let air dry.</p> <p>An observation was conducted on 05/07/14 at 7:05 AM of Nurse # 2 obtaining finger stick blood sugar (FSBS) reading for a resident. Nurse # 2 was observed gathering equipment, entered Resident # 41's room and followed the proper procedure for obtaining the FSBS reading. Upon completion, Nurse # 2 returned to the medication cart, wiped the glucose meter (glucometer) with a germicidal wipe, tossed the wipe into the trash bin, and placed the glucometer into a plastic bag in the medication cart. The glucometer was observed being put into the bag after less than 1 minute after it was wiped by Nurse # 2. Nurse # 2 did not assure the glucometer remained wet for a full 3 minutes and then let air dry.</p> <p>During an interview on 05/07/14 at 7:05 AM directly following the glucometer cleaning Nurse # 2 stated it was facility procedure after utilizing a glucometer to wipe the glucometer down with a germicidal wipe. Nurse # 2 confirmed the glucometer did not remain wet for the full 3 minutes and did not allow the glucometer to air dry before it was utilized again. Nurse # 2 stated she normally wiped the glucometers with a germicidal wipe and placed them into the plastic bags after each use on a resident. Nurse # 2</p>	F 441	<p><i>Continued from page 59</i></p> <p>All reports from compliance rounds will be submitted to Quality Assurance and Performance Improvement Committee monthly for validation of compliance with update/change as indicated</p>	June 6, 2014	

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F 441	<p>Continued From page 60</p> <p>further stated her understanding was the glucometers needed to be wet for only 30 seconds to a minute. Nurse # 2 revealed she was unaware of the procedure of ensuring that the glucometer remained wet with germicidal solution for 3 minutes to complete the disinfecting process and to allow air drying. Nurse # 2 then read the instructions on the germicidal wipe and verified the instructions read that the surface must remain visibly wet for 3 minutes and then let air dry.</p> <p>During an interview on 05/07/14 7:45 AM the Director of Nursing (DON) stated nurses were instructed to clean the glucometers before and after each use. The DON further stated nurses were to sanitize and disinfect glucometers with a germicidal wipe according to manufacturer's directions before used for resident blood glucose monitoring. The DON stated she was unaware of ensuring the glucometer remained wet with germicidal solution for 3 minutes and allowed to air dry to complete the disinfecting process. The DON confirmed the instructions on the germicidal wipe and verified the instructions read that the surface must remain visibly wet for 3 minutes and then let air dry. The DON verified the nurses were not disinfecting the glucometers per manufacture guidelines.</p>	F 441			

