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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING ______ B. WING ______	C 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	**1212 EAST SUNSET DRIVE MONROE, NC 28112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of a complaint investigation Event ID 1H7P11.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide a chair for one of one sampled resident (Resident #69) to use when out of bed that met his needs. The findings included: Resident #69 was admitted to the facility on 6/19/2010 with diagnoses including lymphedema, dementia and history of a stroke. A Physical Therapy (PT) plan of care dated 12/9/13 indicated Resident #69 was unable to get up in a geri chair due to back pain, deconditioning and decrease range of motion in his lower extremities. The PT assessed Resident #69 with severe limited range of motion in the lower extremities, and in hip and knee flexion. He was unable to sit on the edge of bed. PT had instructed nursing and provided education about	F 246	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Resident #69 was referred to therapy on 11/20/14 to re-assess appropriate chair to meet the needs of the resident. Currently, resident #69 is utilizing a Broda chair while up out of bed per physical therapy recommendations. A facility observation was conducted on current population to ensure that residents	12/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/15/2014

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

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F 246	Continued From page 1	F 246		

positioning and his limitations. Nursing staff was advised to get Resident #69 up in a reclining position only. Other instructions included the resident was not able to sit up, stand and required a hoyer lift for transfer.

Review of a note indicating a date of change in function, dated 12/10/13 indicated Resident #69 was using a Broda chair. He had hip and knee contractures and was no longer appropriate for a Broda chair. A referral from PT to restorative was made for positioning in bed for meals. This note did not address a type of chair to be used, to enable Resident #69 to get out of bed.

The care plan updated on 6/5/14 indicated a problem of dependence on staff for activities of daily living. The goal indicated Resident #69 would be able to sit in a wheelchair comfortably with good body alignment. The care plan updated 10/24/14 revealed a problem of refusing to get out of bed. The goal indicated the resident was to be out of bed at least three times a week.

Review of the Minimum Data Set (MDS) dated 10/13/14 revealed Resident #69 required total assistance for bed mobility, transfer, bathing, hygiene and toileting. The MDS assessed Resident #69 with limitation in functional movement of both lower extremities. Resident #69 was assessed as having short and long term memory problems and behavior of rejecting care at least one to three days a week. This MDS assessed the resident as having pain.

Record review revealed the last physician ' s progress note dated 10/9/14 indicated there were no changes in the resident ' s condition. He had dementia without behavioral disturbance. The

have the appropriate chair for accommodation of needs. Any resident noted without a proper chair will be referred to therapy for recommendations.

Staff Development Coordinator and Therapy Manager educated nursing and therapy staff on accommodation of needs related to appropriate chair and interdisciplinary communication between nursing and therapy when chairs are not accommodating the needs of the resident. This information will be included into the new employee orientation program.

Director of Nursing and Unit Managers will audit five residents weekly for twelve weeks to ensure that resident'sK chair accommodates their need.

Director of Nursing will present results of the audits to the Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.

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last psychiatric consult note dated 11/11/14 indicated he was seen for a problem of depression. The consult note indicated Resident #69 was alert, oriented to person, place and time with organized thought process, short and long term memory was fair, insight poor and judgment was poor.

Review of the aide ' s documentation for completion of activities of daily living revealed no refusals of care was documented for the past three months.

Observations on 11/20/14 at 8:58 AM and again at 12:59 PM revealed Resident #69 was in bed.

On 11/20/2014 9:30 AM interview was conducted with the nurse #3, the charge nurse for Resident #69. This nurse explained the resident preferred to stay in his room, did not refuse medications or care provided by staff. He referred to Resident #69 as "very pleasant and easy to work with."
On 11/20/2014 9:54 AM an interview with Resident #69 revealed it was uncomfortable to get a shower at times due to leg and back pain. He further indicated at times he "did not feel well and did not want to go" (to the shower). During the interview, Resident #69 explained he would get out of bed if he had a "comfortable chair." The resident was asked if he had any type of chair to sit in and he stated "No."
Interview conducted on 11/20/2014 10:02 AM with the therapy manager revealed no referrals had been given to them since 8/1/14. The therapy manager explained the current therapy company started with the facility in August 2014. She did not have any records from the previous therapy company and did not know what therapy had been provided for Resident #69. Information

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F 246	Continued From page 3 should be in the medical record. On 11/20/2014 at 10:18 AM an interview was conducted with aide #1. The aide indicated Resident #69 did not refuse care when she was assigned as his aide. She continued to explain sometimes he complained of pain when she went in to do care. His pain was in the right leg and he could not bend his knee. After informing the nurse of his pain, medication would be given and she would return later to provide his care. The aide was asked if the resident would get out of bed and she stated yes, if he had a chair that was supportive and comfortable for him. Interview on 11/20/2014 at 10:30 AM with nurse #4 revealed she was not aware of what type of chair was recommended by therapy after the 12/9/13 level of change note was made. The note was used by nursing and given to therapy for referral. Communication would be made between therapy and the MDS nurse if recommendations or treatment was provided. Interview on 11/20/14 at 11:20 AM was conducted with nurse # 5 and aide #2. Both staff members explained therapy had not informed them how to position Resident #69 in a chair to be out of bed. A geri chair was used before the Broda chair. The Broda chair was not comfortable for the resident when out of bed. Interview with MDS nurse #1 on 11/20/2014 at 11:40 AM indicated the care plan goal for Resident #69 was to sit in a wheelchair. The MDS nurse was not aware therapy had assessed the resident as unsafe in a wheelchair. The nurse explained it was not communicated by therapy he was not to use a wheelchair or a Broda chair. Further interview revealed the lack of communication with therapy may have caused the problem with missing a wheel chair was not	F 246		

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F 246	Continued From page 4 appropriate for the resident.	F 246		
F 253 SS=E	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 observations and staff interviews, the facility failed to maintain cleanliness in 5 of 40 resident rooms inspected (Room # 213, 220, 226, 337, 339) and failed to maintain proper maintenance in 6 of 40 resident rooms (Room # 217, 226, 313, 317, 339, and 356). Findings included: 1. The following housekeeping issues were observed to be in the same condition as described below. Observations were made of these issues at various times throughout the survey period including 11/17/14 at 9:35 AM, 11/18/14 at 1:45 PM, 11/19/14 at 4:20 PM, and 11/20/14 at 8:00 AM: a. Room # 213 - dirty drapes hanging on window. Both drapes had flecks of food, dried substances, and red/brown colored splatters on it. The housekeeping manager was interviewed on 11/20/14 at 09:18 AM. She confirmed that the drapes were dirty and in need of cleaning. She further indicated that the facility did not have any extra curtains and therefore if a resident continues to occupy a room than the drapes cannot be taken down for washing due to privacy	F 253	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is always our policy to provide the necessary Housekeeping/ maintenance services to maintain a sanitary, orderly and comfortable interior to our residents. Specific room issues were addressed immediatley: #1 Room 213: drapes were cleaned/ washed and dried	12/18/14

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F 253	Continued From page 5 concerns. b. Room # 220 - bathroom baseboards dirty at the entrance to the bathrooms and around the bathroom area. The housekeeping manager was interviewed on 11/20/14 at 09:18 AM. She confirmed that the baseboards were dirty and indicated that housekeeping staff should thoroughly clean the baseboard/floor area daily to prevent a build up of grime. c. Room # 226 - air conditioning (AC) unit cover contained a layer of dirt and grime on the outside, and baseboards around the room were black with grime and dirt where they met the floor. The housekeeping manager was interviewed on 11/20/14 at 09:18 AM. She confirmed that the AC unit cover and the baseboards were dirty. She indicated that the housekeeping staff should have wiped the outside cover of the AC unit daily and scraped the baseboards daily. d. Room # 337 - a large wad of hair was observed to be in the tub drain, the tub was dirty and not scrubbed, there was dust on top of the bathroom call bell and on top of the light fixture. The housekeeping manager was interviewed on 11/20/14 at 09:18 AM. She indicated that the bathrooms were cleaned 3 times daily and as needed. She explained that first the staff member would take out trash, then dust the bathroom from top to bottom, then wipe down the walls, then spray a rag with disinfectant and wash sinks/tubs, then use another sprayed rag to wash the toilet. She stated that call bells are wiped	F 253	Room 220: Bath room baseboard was scrubbed and cleaned Room 226: Air Condition filter was cleaned, cover was cleaned and baseboard was scrubbed and cleaned Room 337: Tub was cleaned, scrubbed, call bell light and other fixtures were dusted and cleaned Room 339: Bath room was cleaned Thoroughly. Housekeeping manager will inspect all drapes in resident rooms to ensure its quality and Replace if needed. Housekeeping manager will perform audit for ten resident rooms weekly for three months to ensure rooms are appropriately cleaned, drapes maintained quality and to identify area of improvement if needed. All drapes in resident rooms will be put on quarterly cleaning schedule and as needed if an issue reported prior to the schedule. Staff Development Coordinator will in service nursing staff on proper way to report housekeeping issues. Housekeeping staff will be in-serviced by the housekeeping service manager on the proper procedure of adequate cleaning and provide staff with the cleaning schedule.	

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F 253	Continued From page 6 down too. After pointing out this bathroom, the housekeeping manager agreed that this bathroom had not been cleaned thoroughly per policy. e. Room # 339 - a thick layer of dust was observed on the bathroom call bell and on top of the light fixture of the bathroom, a string from what resembled a cobweb was observed hanging down from the ceiling. The housekeeping manager was interviewed on 11/20/14 at 09:18 AM. She indicated that the bathrooms were cleaned 3 times daily and as needed. She explained that first the staff member would take out trash, then dust the bathroom from top to bottom, then wipe down the walls, then spray a rag with disinfectant and wash sinks/tubs, then use another sprayed rag to wash the toilet. She stated that call bells are wiped down too. She indicated that this bathroom had not been dusted per policy. To all of these issues pointed out, the housekeeping manager agreed that the staff was not cleaning the resident rooms/bathrooms according to policy, during the interview on 11/20/14 at 9:18 AM. She stated that she had never thought to conduct random spot checks on the cleanliness of the room, but indicated that the expectation of the housekeeping staff is that they kept the facility dust-free and clean at all reasonable times. The administrator was interviewed on 11/20/14 at 11:30 AM. He stated that "I expect the facility to be clean and the maintenance issues to be reported between housekeeping and maintenance. I take great pride in having a clean	F 253	Staff signaturs will be collected to ensure staff acknowlegement. Monthly for three months Quality Assurance Committee members will discuss and review the results of the housekeeping audit and make suggestion and recommendations as needed during the Quality Assurance Committee monthly meeting to ensure compliance is sustained ongoing. #2 Specific room issues were corrected immediately. Room 217: Air condition vent was cleaned and cover was placed correctly. Room 226: Air condition vent was cleaned and cover was placed correctly. Room 313: Air condition cover was located in the room and placed correctly. Room 317: Air condition Cover was placed correctly. Room 356: Air condition unit and its cover was placed correctly. Room 339: Bath Room Faucet was fixed and corrected, Light fixture was corrected. The maintenance supervisor will audit ten resident rooms weekly for three months to ensure appropriately maintained rooms and to prevent these issues from recur.	

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F 253	Continued From page 7 and odor free facility. We deep clean every room, one by one, we clean the carpets, pest control is here every other week, and we have changed housekeeping supervisors several times in the 2 years that I have been here. We are constantly working to keep this a nice facility. But we also have identified some of these issues and are working to correct them." A housekeeping staff member was interviewed on 11/20/14 at 12:34 PM. She indicated that she always cleans the entire room and bathroom from top to bottom per policy. She stated that she has even used a pick-like utensil to take food/trash items out of the AC if she saw any. She also indicated that a scraper is provided by the facility to scrape grime from around the floor baseboards. The housekeeping district manager was interviewed at 1:00 PM on 11/20/14. He stated that "We have tried to identify areas of concern in housekeeping and are working to improve them." 2. The following maintenance issues were observed to be in the same condition as described below. Observations were made of these issues at various times throughout the survey period including 11/17/14 at 9:35 AM, 11/18/14 at 1:45 PM, 11/19/14 at 4:20 PM, and 11/20/14 at 8:00 AM: a. Room # 217 - AC unit cover hanging off hinges, AC unit vent contained food/trash items in it. b. Room # 226 - AC unit cover hanging off hinges. The resident in the room stated " Oh	F 253	Maintenance department to follow its monthly audit schedule as its policy requires. Administrator will in service the maintenance supervisor and maintenance assistant on adequate inspection of rooms and preventive maintenance schedule. Maintenance department staff will fix and/or replace any item that does not meet manufacture standards. Staff will be in-serviced by the staff development coordinator on the proper procedure to report any maintenance issue needed to maintenance department. Monthly for three monthsQuality Assurance Committee members will discuss and review the result of the maintenance auditprovided by the maintenance supervisor and make suggestions and recommendations as needed to ensure compliance is sustained ongoing.	

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F 253	Continued From page 8 yeah, you just have to bump it and the cover falls right off. " The AC unit also contained food/trash items in the vent. c. Room # 313 - the cover was missing entirely from the AC unit. The maintenance manager looked in various parts the room and could not easily locate the cover to the unit at that time. d. Room # 317 - AC unit cover off of its hinges. e. Room # 356 - AC unit loose and off hinges on the right side. The maintenance manager was interviewed on 11/20/14 at 11:00 AM. He stated that " We (the manager and his assistant) round daily looking for things to fix inside and outside of the facility. We take verbal and written requests as work orders which we try to get to within an hour to a day's time frame. We know that the AC unit covers are easy to pop off. We have never considered that they could cause injury to a resident. I wasn't aware of the debris in the AC units; if reported or we see it then we (maintenance) would be responsible for cleaning it. I don't know how we missed so many things." f. Room # 339 - bathroom sink faucet loose and bathroom light fixture cover hanging off of its brackets. The maintenance manager was interviewed on 11/20/14 at 11:00 AM. He indicated that both he and his assistant were unaware of the loose faucet or loose light fixture. The maintenance assistant was interviewed at 11:10 AM on 11/20/14. He stated that "I try to	F 253		

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F 253	Continued From page 9 make rounds often, both on the outside and the inside; it could be as often as daily or as random as once weekly. I wasn't aware of all of these issues." The administrator was interviewed on 11/20/14 at 11:30 AM. He stated that "I expect the facility to be clean and the maintenance issues to be reported to and fixed by maintenance."	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a care plan	F 279	This plan of correction is the center's credible allegation of compliance.	12/18/14

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Continued From page 10
for one of three sampled residents with contractures (Resident #69).

The findings included:

Resident #69 was admitted to the facility on 6/19/2010 with diagnoses including lymphedema, dementia and history of a stroke.

A Physical Therapy (PT) plan of care dated 12/9/13 indicated Resident #69 was unable to get up in a geri chair due to back pain, deconditioning and decrease range of motion in his lower extremities. The PT assessed Resident #69 with severe limited range of motion in the lower extremities, and in hip and knee flexion.

Review of the care plan with a revision date of 6/5/14 for a problem of dependence for all activities of daily living included a goal to remain free of complications related to immobility including contractures. There were no approaches for this goal.

Review of the Minimum Data Set (MDS) dated 10/13/14 revealed Resident #69 required total assistance for bed mobility, transfer, bathing, hygiene and toileting. The MDS assessed Resident #69 with limitation in functional movement of both lower extremities. Resident #69 was assessed as having short and long term memory problems and behavior of rejecting care at least one to three days a week. This MDS assessed the resident as having pain.

Observations on 11/20/14 at 8:58 AM and 12:59 PM revealed Resident #69 was in bed with his knees bent at about 90 degrees.

F 279

Preparation and/or execution of this plan os correction does not constitute admission or agreement by the provdier of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Resident #69 care plan reviewed and revised to include contracture management of lower extremity contractures.

An audit was conducted on current resident population to ensure residents with contractures are care planned appropriately and approaches to contractures are evident in the care plan.

Director of Nursing provided re-education to Unit Managers and Minimum Data Set Nurses to validate residents with contractures are care planned appropriately and approaches to contractures are evident in the care plan. This education will be included into the new employee orientation program for Unit Managers and Minimum Data Set Nurses.

Residents admitted to the facility with contractures will be referred to therapy for recommendations and contracture management. Facility residents who develop contractures will be referred to therapy for receommendations and

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F 279	Continued From page 11 Interview with MDS nurses #1 and 2 was conducted on 11/20/2014 11:40:45 AM. MDS nurse #1 was not aware Resident #69 had contractures of the lower extremities. MDS nurse #2 had no response when asked what the approaches were for the goal related to contractures.	F 279	contracture management. Director of Nursing, Unit Managers, Staff Development Coordinator or Nurse Supervisor will randomly audit five residents with contractures weekly for three months to ensure contractures are care planned appropriately and approaches to contractures are evident in the care plan. Monthly for three months, the Director of Nursing will present the results of the care plan audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide treatment for contracture management for one of three sampled residents with contractures (Resident #69). The findings included: Resident #69 was admitted to the facility on 6/19/2010 with diagnoses including lymphedema,	F 311	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan os correction does not constitute admission or agreement by the provdier of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	12/18/14

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F 311

Continued From page 12

dementia and history of a stroke.

A Physical Therapy (PT) plan of care dated 12/9/13 indicated Resident #69 was unable to get up in a geri chair due to back pain, deconditioning and decrease range of motion in his lower extremities. The PT assessed Resident #69 with severe limited range of motion in the lower extremities, and in hip and knee flexion. He was unable to sit on the edge of bed. PT had instructed nursing and provided education about positioning and his limitations. Nursing staff was advised to get Resident #69 up in a reclining position only. Other instructions included the resident was not able to sit up, stand and required a hoyer lift for transfer. The resident did not require physical therapy.

Review of a note indicating a change in function, dated 12/10/13 indicated Resident #69 had hip and knee contractures. The declines were noted as poor positioning in bed and no longer getting up in the Broda chair. The assessment was signed by nurse #4. A referral from PT to restorative was made for positioning in bed for meals. This note did not address contracture management of bilateral lower extremities.

A telephone order dated 12/10/13 indicated Occupational Therapy (OT)evaluation to be completed and treat as indicated.

The OT progress notes, evaluation and discharge summary were not available for review.

Review of the Minimum Data Set (MDS) dated 10/13/14 revealed Resident #69 required total assistance for bed mobility, transfer, bathing, hygiene and toileting. The MDS assessed

F 311

it is required by the provisions of federal and state law.

Resident #69 referred to therapy on 11/20/14 related to contractures in lower extremities and need for contracture management.

An audit was performed on current population to identify residents with contractures. Residents in need of contracture management were referred to therapy for recommendations.

Staff Development Coordinator will educate Licensed Nurses on assessing residents for contractures and referring to therapy for contracture management. Therapy Manager will educate Licensed Physical and Occupational Therapist on appropriately evaluating residents for contractures and establishing a contracture management program with effective communication of program to interdisciplinary team. This education will be included into the new employee orientation for Licenses Nurses, Physical Therapist and Occupational Therapist.

Residents admitted to the facility with contractures will be referred to therapy for recommendations and contracture management. Facility residents who develop contractures will be referred to therapy for recommendations and contracture management.

Therapy Manager will randomly audit five residents monthly for three months to

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F 311	Continued From page 13 Resident #69 with limitation in functional movement of both lower extremities. Resident #69 was assessed as having short and long term memory problems and behavior of rejecting care at least one to three days a week. This MDS assessed the resident as having pain. The care plan updated 10/24/14 for a problem of dependent on staff for activities of daily living. The goal included Resident #69 would be free of complications related to immobility, including contractures. There were no approaches for this goal included in the care plan. Interview on 11/20/2014 10:02 AM with the therapy manager revealed she had not received therapy referrals for Resident #69 from 8/1/14 to present (11/20/14). She explained her therapy company had started in August 2014 and she did not know what had been provided by the previous therapy company for Resident #69. Interview on 11/20/2014 at 10:30 AM with nurse #4 revealed the change in physical function form dated 12/10/13 was given to therapy. Therapy would evaluate for possible therapy. The MDS nurses would be informed by therapy when treatment was started and of any changes in their care. unable to find OT note. Interview with nurse #5 on 11/20/14 at 11:20 AM revealed Resident #69 had been on their caseload for restorative. Treatment provided was active range of motion of the upper extremities and positioning in bed for meals. The resident was discharged from restorative in May 2014. Nurse #5 explained the resident had met the goals. Resident #69 had not received treatment	F 311	validate residents with contractures are properly evaluated and recommendations for contracture management are established and communicated with the interdisciplinary team. Monthly for three months, the Quality Assurance and Performance Improvement Committee will review the results of the contracture management audit presented by the Therapy Manager. The Quality Assurance and Performance Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	

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F 311	Continued From page 14 for the management of contractures of the lower extremities. Interview with aide #2 on 11/20/14 at 11:20 AM revealed she had provided active range of motion to the upper extremities for Resident #69. Further explanation revealed she had been assigned to provide care for Resident #69 after discharge from restorative. Resident #69 had contractures of the knees which had not changed. She explained the resident remained at the same level of functioning since discharge from restorative. Interview with MDS #1 and 2 on 11/20/2014 at 11:40 AM indicated they were not aware of the plan for contracture management for Resident #69. A lack of communication with the previous therapy group may have caused the problems.	F 311		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to have a medication error rate less than 5%. Medication error rate was 7.7% for an observed medication pass with 2 errors out of 26 opportunities. Findings include: On 11/19/14 at 8:50AM nurse #1 was observed	F 332	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan os correction does not constitute admission or agreement by the provdier of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	12/18/14

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F 332	Continued From page 15 administrating Glipizide 5mg (used to treat type 2 diabetes) to resident #36. A review of the physician orders for the month of November 2014 revealed an order that read "Glipizide 5mg (milligrams) take 1 tab by mouth every day administer before meals". On 11/19/14 at 8:50AM resident #36 was observed with a tray that had empty plates on it. On 11/19/2014 10:47:39 AM an interview with nurse #1 revealed that resident #36 got breakfast about 7:30am; usually breakfast comes between 7:30am and 8:00am. Further discussion revealed that resident #36 doesn't like to take anything on an empty stomach so we give it to her after breakfast. "I should get the order changed" On 11/19/14 at 4:14PM nurse #2 was observed administrating Sansipar (used to treat over activity of the parathyroid gland) 60mg to resident #81. A review of the physician orders for the month of November 2014 revealed "Sansipar 60mg take by mouth every day with evening meals. . On 11/20/14 at 9:31AM interview with nurse #2 revealed that when he had a resident who needed to take their medications with meals he usually held it back until a resident has their meal .When asking the nurse if he gave the sensipar with a meal nurse #2 stated "no I did not, I did not realize it was to be given with meals". On 11/20/2014 at 9:48AM an interview with the Director of Nursing revealed that her expectation would be that the nurses read the order and administer the medications as the physician ordered.	F 332	it is required by the provisions of federal and state law. Nurse #1 and Nurse #2 were provided one to one education on medication administration and appropriately following physicianK's orders for medication administration. After education was provided, Nurse #1 and Nurse #2 were observed by the Staff Development Coordinator on medication administration pass two times with no medication errors observed. Licensed Nurses were provided re-education by Staff Development Coordinator on medication administration and appropriately following physician's orders for medication administration. This education will be included into the new employee orientation program. Director of Nursing, Unit Managers, Staff Development Coordinator or Nurse Supervisor will randomly observe five nurses per week to validate competency with medication administration and following physicianKs orders for medication administration. These observations will be completed weekly for twelve weeks. Any Licensed Nurse who is observed to have an error will be removed from the medication pass, provided additional education, and will not be permitted to perform medication administration pass alone until deemed proficient by the Director of Nursing, Unit Managers, Staff Development Coordinator or Nurse Supervisor. Audit results will be	

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F 332	Continued From page 16	F 332	presented to the center'Ks monthly Quality Assurance and Performance Improvement Committee. The Director of Nursing will present the medication administration pass audit results to the Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews the facility failed to access dental services for 1 of 1 resident. (Resident #1)	F 411	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute	12/18/14

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F 411	Continued From page 17 Findings include: Resident #8 was admitted to the facility originally on 6/16/06 and re-admitted on 7/22/14. Diagnosis included: Cerebrovascular disease, Diabetes type II, Depressive Disorder, Hypertension, Peripheeral Vascular disease and pre-senile dementia with depressive features. A review of the quarterly Minimum Data Set dated 10/8/14 revealed the resident had a brief mental status score of 15; which indicates the resident was able to make her own decisions. Further review of the quarterly MDS dated 10/8/14 revealed no dental concerns were coded. A review of Resident #8's medical record revealed there was 1 dental consult which was dated 3/30/12. There was no other documentation available indicating Resident #8 had been seen by a dentist since. A review of the form used by the facility to complete an assessment was reviewed. The facility form assessing Resident #8 dated 10/2/14 under the section titled 'Oral Status' indicated that Resident #8 had dentures. The section for upper dentures had full marked. The section to indicated if the resident had lower dentures was blank and the section indicating if the dentures were with a resident was blank. A review of the current car plan dated 10/8/14 identified a problem for nutritional risk, there was no indication that Resident #8 did not have bottom dentures or any difficulty chewing. A review of the quarterly dietary assessment note dated 10/8/14 documented Resident #8 had no	F 411	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility scheduled a dental appointment for Resident #8. Dental appointment scheduled for December 18th, 2014. An audit was conducted on current resident population to assess oral status and determine if dental services are needed. If dental services were needed, the physician and responsible party were advised and a dental consult was requested. If the physician and responsible party were in agreement with the dental consult, the facility Social Worker ensured dental appointment was scheduled. Director of Nursing provided re-education to Social Services Director on ensuring access to routine and emergency dental services. Staff Development Coordinator provided re-education to Licensed Nurses on oral status assessments and if necessary referral to Social Services Director to ensure dental services are promptly scheduled if oral assessment reveals need for dental services and/or resident request dental services. This information will be included in general orientation for newly hired Licensed Nurses and/or newly hired Social Workers.	

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F 411	Continued From page 18 chewing problems. On 11/17/14 at 4:03PM an interview with Resident #8 revealed that she had bottom dentures but they do not fit so she does not wear them. On 11/18/14 at 11:05AM Resident #8 was observed lying in bed and had no bottom teeth. On 11/20/2014 at 10:38AM an interview with Resident #8 revealed that there were some foods that she could not chew. The resident indicated that some of the meat was tough and she was not able to chew it. Further discussion revealed that Resident #8 would like to have bottom dentures. Resident #8 could not remember when her bottom dentures did not fit any more. On 11/20/2014 at 10:42AM an interview with the social worker revealed that she made the appointments with the facility dentist when a resident/family requests to see a dentist. we have a dentist that comes here when a resident requests to see a dentist "I make an appointment". Further discussion revealed that the dentist comes to the facility to provide services. On 11/20/14 at 12:57PM an interview with the Assistant Director of Nurses (ADON) revealed that she had completed the quarterly assessment on 10/8/14 for dental issues. Further discussion with the ADON revealed that "I never paid any attention if she was wearing them". ADON indicated there wad no documentation available regarding Resident #8 not wearing her bottom dentures. ADON indicated staff were aware of resident #8 not wearing dentures but could not	F 411	Director of Nursing, Unit Managers, Staff Development Coordinator or Nurse Supervisor will randomly perform oral status assessments on ten residents weekly for three months to validate dental services are provided as needed. During observations by Director of Nursing, Unit Managers, Staff Development Coordinator or Nurse Supervisor, if a resident who requires dental services has not received a dental consult, the auditor will contact the physician and responsible party to request a dental consult. If the physician and responsible party are in agreement with the dental consult, the facility Social Worker will ensure the dental appointment is scheduled. The auditor will in-service the Licensed Nurse caring for any resident who requires, but does not have a dental consult ordered. Monthly for three months, the Director of Nursing and Social Services Director will present dental audits and number of residents consulted for dental services to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	

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F 411	Continued From page 19 find any information that the facility made any attempt to get an appointment with the dentist to resolve the issue.	F 411		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		12/18/14

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F 431	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label medication stored in a medication cup; failed to properly destroy medication not in the original package and failed to keep liquid bottles clean on 1 of 4 medication carts. Findings include: On 11/20/2014 at 12:19PM medication cart 2 east was observed to have a medicine cup with 3 small white pills in it. The medication cup was sitting in the top drawer. The medication cup had no indication what the pills were and who the pills were for. Nurse #3 who was assigned to the medication cart stated "those are lexapro; I pulled this morning by error. The medication was to be given at 9:00PM and I kept them rather destroying it". On 11/20/2014 at 12:19PM medication cart 2 east was observed to have loose pills lying on the bottom of the second drawer on the medication cart. There were 6 whole white colored pills and 1/2 pill lying on the bottom of the second drawer of the medication cart. In the third drawer of the medication cart 3 pills were observed lying on the bottom of the drawer. On 11/20/14 at 12:19PM on medication cart 2 east the third drawer was observed to have 1 bottle of amantadine hydrochloride oral solution that had a thick edge around the bottle top of white colored substance and white colored substance spots down the top of the bottle and	F 431	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Nurse #3 was provided one to one education on properly storing medication, properly destroying medication not in the original package and maintaining a clean and orderly medication cart including ensuring liquid bottles are kept clean. Medications unlabeled and not in the original package found on the medication cart on 2 East were immediately destroyed properly. Liquid medication bottles on the medication cart on 2 East were cleaned. Facility medication carts were audited to ensure proper storage of medication, proper destruction of medication not in the original package and verification of clean and orderly medication cart including ensuring liquid bottles are clean. Licensed Nurses were re- educated by Staff Development Coordinator on properly storing medications, properly destroying medication not in the original	

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F 431	Continued From page 21 across the label. Some of the information on the label was not readable. A 12oz. (ounce) bottle of geri mox liquid had white colored substance down the front of the label and the cap had white colored substance where it connects to the bottle. On 11/20/2014 at 12:45PM nurse #3 stated each shift is responsible for keeping the cart clean this is my first time on this hall "I am a floater". On 11/20/2014 at 12:46PM an interview with the Director Of Nursing revealed that each nurse on cart is responsible for cleaning carts, cleaning up spills. The third shift usually checks the carts for expired medications and clean the carts.	F 431	package and maintaining a clean and orderly medication cart including ensuring liquid bottles are kept clean. This education will be included into the new employee orientation program. Director of Nursing, Unit Managers, Staff Development Coordinator or Nurse Supervisor will randomly observe the center'Ks medication carts twice weekly for four weeks then weekly for eight weeks to validate medications are stored properly, medications not in the original package are destroyed properly and medication carts are clean and orderly including ensuring liquid bottles are clean. Observation results will be presented to the center'Ks monthly Quality Assurance and Performance Improvement Committee. The Director of Nursing will present the results of the medication cart audits to the Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469		12/18/14

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F 469	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to implement an effective pest control program in 2 of 3 halls (200 and 300 halls). Findings included: An observation was made on 11/17/14 at 10:00 AM. Three flies and 1 gnat were seen in room 356. Neither resident residing in room 356 was interviewable. An observation was made on 11/18/14 at 2:15 PM. Nurse #4 was seen swatting at a fly around the nurses station on the 300 hall. An observation was made on 11/20/14 at 10:30 AM with the maintenance manager. Four flies and 1 gnat were seen in room 356. An observation was made on 11/20/15 at 2:50 PM. One fly was seen in the 300 hall dining room area during the exit interview. The administrator ducked his head from the flying path of the pest. Nurse #4 was interviewed on 11/20/14 at 10:46 AM. She stated that flies do tend to accumulate in room 356 because the resident in B bed tends to knock over drinks and food often. She indicated that she has called to alert housekeeping of the spills but does not think they are doing a thorough job cleaning the room and keeping it clean to alleviate the accumulation of the pests. She further indicated that in the past she has alerted maintenance of the pest issues, and was told to "Contact housekeeping; that's their responsibility." The maintenance manager was interviewed on	F 469	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is always our policy and practice to provide and maintain an effective pest control program so the facility is free of pest and rodents. Room 356: was deep cleaned immediatley, 300 hall nursing station was cleaned , 300 hall dining room was deep cleaned, The hall area around the room 356, 300 hall nursing station and dining room were cleaned and the carpet was extracted. The facility will provide out door area(courtyard), maintenance door area which leads to 300 hall and nursing station with extra fly traps. Also, the facility will provide extra indoor light fly traps around courtyard and maintenance door in 300 hall and 300 hall dining room hall way and nursing station area to prevent and reduce risk of flys entering the building.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING ______ B. WING ______	C 11/20/2014

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F 469	Continued From page 23 11/20/14 at 11:00 AM. He verified that pest control falls under the duties of housekeeping. He provided documentation of all the visits made to the facility by the contracted pest control agency, which were dated 11/1//14, 10/14/14, 10/4/14, 9/8/14, and 8/11/14. He indicated that the side door on the 300 hall is used by residents and staff to access the smoking area, allowing access for flying pests into the facility. He further indicated that other than contacting the pest control agency, the facility had not tried any other means of controlling the issue with the flying pests. He also indicated that no one had brought to his attention that pests tend to accumulate in room 356. Nurse #4 stated at 11:08 AM on 11/20/14 that she, herself, cleaned room 356. She stated that "Housekeeping really should be keeping a close eye on rooms like that because this is their (residents') home and we wouldn't want flies in our home." The housekeeping manager was interviewed on 11/20/14 at 11:20 AM. She indicated that she was not aware or the persistent problem of pest accumulation in room 356. She indicated that she has called for pest control service each time she was alerted to an issue. The administrator was interviewed on 11/20/14 at 11:30 AM. He stated that he prided himself on improving the cleanliness of the facility over the past 2 years but has not considered any other measure of pest control other than contacting the agency. He indicated that he was not aware that flying pests were a problem in the facility.	F 469	Resident rooms and hallways will be free from gnats and fly prsence. Staff Development Coordinator will educate staff on the proper procedure for reporting any pest control issues to housekeeping manager. Staff signatures will be collected at each in service to ensure staff acknowledgement. Maintenance manager to ensure the reported issue is corrected. Pest control provider to be called in immediatley if needed. The monthly visit by the pest control provider will be monitored closly by the Manitenance Manager, and will check and report its effectiveness to the administrator and adjust accordingly. The housekeeping supervisor will randomly observe five resident rooms weekly for three months for exessive fly presence. The housekeeping manager will observe the 300 hall area for exessive fly presence weekly for three months. Monthly for three months, the Quality Assurance and Performance Improvement Committee will review and discuss the audits of the pest control program presented by the Housekeeping Manager. The Quality Assurance and	

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F 469	Continued From page 24	F 469	Performance Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	