STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	01/29/2015

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SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on physician and staff interviews and review of medical records, the facility failed to notify the physician of no improvement in a	F 157	Resident # 64 noted as discharged. Audit entitled "Antibiotic Nonresponse, Physician Notification Audit" to be	2/26/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/23/2015

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F 157	Continued From page 1 resident ' s condition for 1 of 1 sampled resident (Resident # 64) . Findings included: Resident # 64 was most recently readmitted on 1/19/15 with cumulative diagnoses pneumonia and Alzheimer's disease. On 1/9/15 at 11:26 PM, the nurse documented at 4:00 PM Resident # 64 ' s temperature was 100.4 axillary (taken under the arm pit), pulse 102, and blood pressure (BP) 129/57. The nurse also documented Tylenol was given per standing orders for the temperature. A chest X-ray (CXR) was ordered and completed showing pneumonia. The physician ordered Levaquin (an antibiotic) 500 milligrams (mg) daily for 10 days. The resident ' s temperature was rechecked (no time given) with a documented result of 99.5 axillary. Nurse's notes for 1/10/15 at 3:06 PM indicated the resident's temperature was 101.2. Tylenol was given. BP was 102/80 and pulse 66. Recheck of Resident # 64 ' s temperature (no time given) was 100.0. The nurse documented she passed the information to the oncoming nurse. At 10:08 PM, the resident's temperature was 99.7 (no route given). Resident # 64 ' s BP was down to 88/45. The nurse documented she heard audible congestion throughout chest and the resident was unable to bring up mucus. There was no documentation that indicated Resident #64 ' s condition was reported to the physician. Nurse ' s notes for 1/11/15 at 7:36 AM recorded a BP of 85/55 and a pulse of 99.2 with a respiratory rate of 20 and heart rate of 92 for Resident # 64.	F 157	completed by 2-26-15 by Staff Development Coordinator to reflect those residents, currently on antibiotics, response to their medical plan of care, and to ascertain that the attending physician has been notified if present regime not proving to be appropriate and/or effective within a 72hr timeframe. All licensed nursing staff assigned to Resident #64 during this initial course of treatment to be counseled by 2-26-15 by Director of Clinical Services as related to their failure to provide non response of antibiotic therapy within 72hrs to the physician regarding the resident's failure to improve. Staff Development Coordinator to conduct in-services to be competed no later than 2-26 15 for licensed nursing personnel regarding direction to obtain vital signs every shift for all residents on antibiotic therapy for the first 72 hours of treatment, documenting the vital signs in the clinical record and also on the designated clipboard at each nursing unit to ensure/alert the nursing supervisor/team leader of the residents status concerning improvement or not improving with current antibiotic course of therapy, and further that the signature of each shift's supervisor will be obtained/secured on this vital sign flow sheet denoting his/her awareness and subsequent notification to the attending physician of change in condition; i.e., fever, not improving. Quality Assurance Coordinator to perform audits entitled "Antibiotic Nonresponse, Physician Notification Audit" beginning twice weekly X1 week, weekly X 1 month,	

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F 157	Continued From page 2 At 2:56 PM, the nurse recorded a temperature of 100.2 at 2:00 PM. At 10:04 PM, the resident's temperature was recorded as 100.3 with a recheck at 8:30 PM after Tylenol was given with a result of 98.0. There was no documentation the physician was notified. On 1/13/15, the resident ' s temperature was 98.9. On 1/14/15 at 3:49 PM, the nurse's note indicated Resident # 64 ' s temperature was 99.2. The nurse added Resident # 64 started treatment for pneumonia on 1/9/15, but continued to exhibit intermittent fevers. The physician was notified and an order received to send to the Emergency Department (ED) for pneumonia not responding to antibiotics. Multiple attempts were made to interview the nurse for Resident # 64. The Director of Nursing (DON) was interviewed on 1/30/15 at 11:27 AM. He stated he expected nurses to notify the physician if an antibiotic had not made a positive difference in the resident ' s condition within 48-72 hours after initiation. The DON acknowledged waiting 5 days to notify the physician of lack of improvement in the resident ' s condition while on an antibiotic was unacceptable. The resident ' s physician was interviewed via telephone on 1/30/15 at 4:45 PM. He stated he had ordered antibiotics for the resident on 1/9/15. After that, there had been no communication with the facility until 1/14/15 when she was sent to the ED. He stated that call from the facility on 1/14/15 was precipitated by the family member.	F 157	monthly X 1 quarter and quarterly there after, of vital sign flow charts at each nursing unit and clinical review of medical charts to determine facility's compliance of notification to physic1an of resident's failure to respond to current antibiotic being prescribed. First audit to be completed no later than 2-26-15. Any Licensed Nursing Staff failing to provide said charting/notification shall be provided written counseling within 24hrs of audit completion and physician notification of such notified upon audit discovery. "Antibiotic Nonresponse, Physician Notification Audit" audits will be included within the minutes of the Quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness.	

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F 157	Continued From page 3 The physician added he would have expected the facility to call if Resident # 64 ' s condition had not improved in 48 to 72 hours. The physician added notification had been an on-going issue with the facility.	F 157		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to honor residents choice to have bilateral side rails for 1 (Resident #2) of 4 residents reviewed for choices. The findings included: Resident #2 was re-admitted to the facility on 12/24/2009, with diagnosis to include paraplegia, seizures, muscle spasms, and multiple joint contractures. His Minimum Data Set (MDS), dated 1/16/2015 listed his cognition as intact and his functional status as total dependence on staff for activities of daily living, transfers, and mobility. The Resident ' s Fall Risk Assessment was dated 10/21/2014 and was coded as 10, which represented a high risk status. The most current fall risk completed was dated 1/16/2015 and was coded as a 12, which represented a high risk status. A review of an incident/accident report of	F 242	Request for dual side rails to be honored for resident #2 and initiated by Director of Nursing on 2-16-15. Primary physician notified 2-16-15 by Director of Nursing of resident's choice and physicians order obtained as to honor request. Psychological services notified 2-16-15 by Director of Nursing of resident #2's choice as to assess residents level of fear/anxiety and continued desire for dual side rails. Side rails shall be care planned accordingly, to reflect resident #2's choice and reassessed quarterly and prn. Administrative/Management Nursing in-serviced by Staff Development Coordinator no later than 2-26-15 for recognition of current residents' rights/choices for request for unmet needs in all interactions during this process and	2/26/15

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F 242	Continued From page 4 12/14/2014, recorded a fall by the Resident at 3:45 AM. Resident was awake, and reading when he slipped out of bed. He suffered a nose bleed and a hematoma (bruise) to the left side of his head. The resident was sent to the emergency room at 5 AM due to decreasing blood pressure. A review of the nurses notes on 12/14/2014 at 7:32 AM reported that the Resident called to the nursing assistant (NA) at 3:45 AM. NA found the resident laying on the floor face down. Resident stated he slipped out of bed. The nurse had written, " Possible due to spasms that the resident had periodically. " The Resident was gotten up via the mechanical lift. Resident was sent to the hospital at 5 AM, and the hospital called at 7 AM and stated the Resident was on his way back to the facility. On 1/26/2015 at 4:50 PM, in an interview with Resident #2, the Resident stated that he had a fall a month and half ago. The Resident was sitting up in bed and the bed was elevated with one side rail up, at the time of the interview. The Resident stated he requested a second side rail up when he was sitting up in the bed, but the facility told him they couldn ' t put up a second rail, because that would be a restraint and the state would not allow it. The Resident stated that he was scared he would fall out of bed again. He stated he has spasms that he can ' t control, and that he viewed the second side rail up as a safety measure and not a restraint. He requested help in getting a second side rail for his safety. On 1/26/2015 at 5:05 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON stated that he had spoken with the Resident and told him they could not put up a restraint, but that they had notified the resident ' s doctor, and she was going to	F 242	in the future and to follow up accordingly within regulatory guidelines during this process. In-service conducted by Staff Development Coordinator to be completed no later than 2-26-15, in regards to resident rights, with concentration and focus on, but not limited to choices about aspects of life in the facility that are significant to the resident. Facility wide audit entitled "Choice Survey" to be completed by no later than 2-26-15 by Quality Assurance Coordinator to canvas all current alert and oriented residents to include, but not limited to choices about significant aspects of life such as health care interest, assessments, plan of care and interacting with members of the community both in and outside of the facility. Any residents voicing concerns shall be referred to nursing for care plan adjustment to reflect said choice. Surveys entitled "Resident Satisfaction Audit" to be completed by Quality Assurance Coordinator beginning twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly there after. First survey to be completed no later than 2-26-15. Survey to include directed questioning regarding satisfaction of residents with choice about aspects of life in the facility that are significant to the resident. Resident #2 to be included in next scheduled Resident Satisfaction Survey. Resident Satisfaction Surveys conducted by Quality Assurance Coordinator will be incorporated into the Quarterly Quality Assurance Committee to	

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F 242	Continued From page 5 adjust his medication to try and control the spasms better. On 1/27/2015 at 11:00 AM, a second interview was conducted with Resident #2. The Resident stated he can use his call light to call the nurse, if the call light is placed by head on the pillow, when he wanted the second side rail down. He stated that he usually calls out for staff, or calls them by name, and they will come into his room to assist him. He stated that his doctor did increase the medicine for his muscle spasms, but he had not noticed any difference, and he still has uncontrollable muscle spasms. He stated that he is apprehensive that he will fall out of bed again, and that is why he had asked for a second side rail. The Resident stated that he used a chest strap, which went around his chest and the wheelchair, to keep him in his wheelchair. He was not comfortable in the wheelchair without it and he doesn ' t call it a restraint, but he called it safety. The Resident was again observed with his bed elevated and the head of bed elevated, with one side rail up. On 1/28/2015 at 3:52 PM, an interview was conducted with Nursing Assistant #9 (NA #9). The NA stated Resident #2 required total care, which included turning him every 2 hours, and feeding him. She stated the Resident liked to read and would put his call light on to have someone come and turn the page. She stated it required 2 staff and the mechanical lift to get the resident up in the wheelchair, and then they would put a chest strap around him and the wheelchair. An interview was conducted on 1/28/2015 at 4:00 PM with Nurse #5. The Nurse stated the resident required total care, and he used his call light to get help. She stated he will also call a nurse by name when they pass his door if he needs	F 242	ensure ongoing compliance as it relates to maintaining residents rights specific to choice about aspects of life in the facility that are significant to the resident.	

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F 242	Continued From page 6 something. She stated that the Resident has called the nurse in to reposition him if he feels like he is too close to the edge of the bed. The resident used a wedge behind his back to help with positioning. An interview was conducted with the DON on 1/29/2015 at 4:40 PM. The DON stated that a second side rail up for this resident would be considered a restraint, even though he cannot get out of bed by himself. The DON stated that the chest strap that is used while the Resident is in the wheelchair is not a restraint because the Resident is unable to access it because of his condition. He stated that he did not want to put up a second side rail out of fear of a citation from the State.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278		2/26/15

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F 278	Continued From page 7 willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and review of the medical record, the facility failed to code an accurate Minimum Data Set (MDS) for 3 of 20 sampled residents (Resident # 140, 242 and Resident # 229) involving dialysis, use of a ventilator while not a resident and dental condition. Findings included: 1. Resident # 229 was readmitted on 1/4/15 with diagnoses that included end stage renal disease requiring dialysis A Quarterly MDS, dated 1/9/15, did not code dialysis under Special Treatments. An interview was held with the MDS nurses on 1/30/15 at 12:45 PM. MDS nurse # 3 stated dialysis should have been captured under special treatments. She acknowledged this was a MDS inaccuracy. 2. Resident # 140 was readmitted on 3/14/11 with diagnoses that included diabetes and glaucoma. An observation on 1/27/15 at 8:29 AM revealed	F 278	1. Resident #229's current MDS(Minimum Data Set) assessment modified by MDS coordinator to reflect dialysis under section O. special treatments, procedures and programs. MDS nurse #3 to be counseled by 2-26-15 for inaccurate coding of MDS assessment by Director of Nursing. In-service training for full time MDS licensed nursing staff to be conducted no later than 2-26-15 by MDS Coordinator regarding MDS assessment accuracy and coding per CMS's RAI Version 3.0 manual. Facility wide audit entitled "Initial and/or Quarterly MDS Coding/Care Planning Accuracy Audit" to be completed no later than 2-26-15 by MDS coordinator to ensure all current residents receiving dialysis treatment have been coded accurately on current MDS assessments. MDS assessment accuracy audits to be completed upon admission and/or twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly therafter by MDS coordinator to monitor for accuracy of coding related to section O. special treatments procedures and programs.	

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F 278	Continued From page 8 Resident # 140 had broken teeth. An Annual MDS with a date of 1/14/15, indicated Resident # 140 had no broken natural teeth or tooth fragments identified on the MDS. The resident's care plan (chart copy), last reviewed 1/19/15, did not address dental issues. The Quality Assurance nurse was interviewed on 1/29/15 at 2:00 PM. He stated based on his observation, the resident had broken teeth. MDS Nurse # 1 and MDS Nurse # 3 were interviewed on 1/30/15 at 12:45 PM. She stated she completed Resident # 140 ' s MDS and had physically assessed the resident ' s dental status. The MDS nurse could give no explanation why the broken teeth were missed during assessment. MDS # 3 identified this error as a MDS inaccuracy. 3. Resident # 242 was admitted on 12/23/14 with an exacerbation of chronic obstructive pulmonary disease (COPD) which had required ventilator support and altered mental status. Review of the Hospital Discharge Summary, dated 12/23/14 indicated COPD with acute exacerbation now resulting in acute respiratory status and intubation, status post extubation. The summary indicated after extubation Resident # 242 was maintained on oxygen received through a nasal cannula. The 12/27/14, 5 day Admission Minimum Data Set (MDS) indicated the resident was cognitively intact. Acute respiratory failure was listed as an active diagnosis. Special treatment in the last 14	F 278	These MDS assessment accuracy audits shall be included in the agenda of the Quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness. 2. Resident #140's MDS assessment modified by MDS coordinator to reflect broken teeth under section L. oral/dental status. MDS nurse #3 to be counseled by 2-26-15 for inaccurate coding of MDS assessment by Director of Nursing. In-service training for full time MDS licensed nursing staff to be conducted no later than 2-26-15 by MDS Coordinator regarding MDS assessment accuracy and coding per CMS's RAI Version 3.0 manual. Facility audit entitled "Initial and/or Quarterly MDS Coding/Care Planning Accuracy Audit" to be completed by 2-26-15 by MDS coordinator as to ascertain accurate coding of current residents oral/dental status under section L. oral/dental status of the MDS assessment. MDS assessment accuracy audits to be completed twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter by MDS coordinator to monitor for accuracy of coding related to section L. oral/dental status. MDS assessment accuracy audits shall be included in the agenda of the Quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness. 3. Resident #242 noted as discharged. MDS nurse to be counseled by 2-26-15 for inaccuracy of coding of MDS	

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F 278	Continued From page 9 days, while not a resident, did not include the use of a ventilator. Oxygen was coded as used. .	F 278	assessment by Director of Nursing. In-service training for full time MDS licensed nursing staff to be conducted no later than 2-26-15 by MDS Coordinator regarding MDS assessment accuracy and coding per CMS's RAI Version 3.0 manual. Facility audit entitled "Initial and/or Quarterly MDS Coding/Care Planning Accuracy Audit" to be completed by 2-26-15 by MDS coordinator as to ascertain accurate coding of current residents use of ventilator status under section O. special treatments, procedures and programs. MDS assessment accuracy audits to be completed upon admission and/or twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter by MDS coordinator to monitor for accuracy of coding related to section O. special treatments, procedures and programs. MDS assessment accuracy audits shall be included in the agenda of the Quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness	
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	F 279		2/26/15

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F 279	Continued From page 10 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 staff interview and record review the facility failed to care plan broken natural teeth for 1 of 2 sampled residents (Resident # 140) reviewed for dental problems. Findings included: Resident # 140 was readmitted on 3/14/11 with diagnoses that included diabetes, glaucoma and depression. The 8/29/14, Registered Dietician (RD) note indicated the resident had lost 14 pounds or 9% in 3 weeks. Resident # 140 ' s dental status was not addressed. A general nurse ' s note for the annual assessment, dated 1/14/15 at 12:16 PM, indicated Resident # 140 required extensive assistance with bathing and hygiene. The note indicated the resident had no upper teeth and just a few of her own lower teeth.	F 279	Resident #140's care plan and current MDS(Minimum Data Set) assessment shall be modified no later than 2-26-15 by MDS nurse to reflect broken natural teeth. MDS nurse #3 counseled for inaccurate coding of MDS assessment and failure to care plan broken natural teeth by Director of Nursing. Facility audit entitled "Initial and/or Quarterly MDS Coding/Care Planning Audit" completed by MDS coordinator as to ascertain accurate coding of current residents oral/dental status under section L. oral/dental status of the MDS assessment with corresponding care plan to be have been completed. In-service training to be completed by 2-26-15 for full time MDS licensed nurses conducted by MDS Coordinator regarding care planning to include, but not limited to, care planning concentrated for broken natural teeth. MDS assessment accuracy/care planning audits entitled "Initial and/or Quarterly	

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F 279	Continued From page 11 An Annual Minimum Data Set (MDS) with a date of 1/14/15, indicated broken natural teeth or difficulty chewing were not identified. Dental issues were not identified as requiring a care area assessment. The Annual RD Assessment, dated 1/15/15 at 3:37 PM indicated Resident # 140 was on a mechanical soft diet. Dental status was not addressed in the note. The MDS nurses were interviewed on 1/30/15 at 12:45 PM. MDS nurse # 1 stated she was unsure why she did not code broken teeth on the annual MDS. MDS nurse # 3 stated without dental problems triggering (identification of a problem), dental issues would not been identified for care plan. MDS nurse # 3 added a care plan should have been developed for Resident # 140 ' s broken teeth.	F 279	MDS Coding/Care Planning Audit" to be completed twice a week X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter by MDS coordinator to monitor for accuracy of coding related to section L. oral/dental status and corresponding care plans to match. Initial audit to be completed by 2-26-15. MDS assessment accuracy audits shall be included in the agenda of the Quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain an order for the administration of oxygen for 1 of 1 sampled resident (Resident #242) that received oxygen. Findings included: Resident #242 was admitted on 12/23/14.	F 281	Resident #242 noted as discharged. Admission nurse for resident #242 to be counseled no later than 2-26-15 by Director of Nursing for failure to obtain written physicians order for the administration of oxygen for resident #242. Nurses #1, #2 and all assigned licensed nurses to resident #242 from	2/26/15

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F 281	Continued From page 12 Admitting diagnoses included acute respiratory failure and altered mental status. The Hospital Discharge Summary, dated 12/23/14 indicated chronic obstructive pulmonary disease (COPD) with acute exacerbation now resulting in acute respiratory status and intubation-status post extubation. Nurse's notes for 12/23/14 at 4:19 PM indicated Resident #242 was on oxygen continously. Review of the physician's admission orders and the physician's telephone orders failed to reveal an order for the continuous oxygen. Review of the 12/27/14 Admission Minimum Data Set (MDS) indicated Resident #242 received oxygen. Review of the December 2014 Medication Administration Record (MAR) and the Treatment Administration Record (TAR) did not include an entry for the use of oxygen. Nurse #1 was interviewed on 1/29/15 at 3:32 PM. Nurse #1 stated orders were required for continuous oxygen with the amount of liters per minute received specified. The nurse added oxygen orders were included on the MAR and/or the treatment sheet. The nurse reviewed the nurse's note for 12/27/14 and stated she had written the note. Nurse #1 added if she wrote the word " on-going " , it meant Resident #242 received oxygen continuously. The nurse was unable to recall how many liters per minute the resident received. She stated she could not remember where she received the order. Nurse #1 reviewed admission orders, the MAR and the TAR and acknowledged there was no order for	F 281	12-23-14 through 12-26-14 provided written counseling by Director of Clinical Services for administration of oxygen without a written physician's order. Facility wide audit entitled "Resident Oxygen Order Audit" to be completed no later than 2-26-15 by Quality Assurance Coordinator to canvas all residents as to ascertain and ensure all current residents receiving oxygen administration have active corresponding physicians orders and documentation of such in the medication administration record. Licensed nursing staff in-services to be completed by 2-26-15 by Staff Development Coordinator related to requirement of physicians orders for oxygen administration and documentation of such in the medication administration record. Written Counseling and in-servicing to be provided to Quality Assurance Coordinator no later than 2-26-15 by Director of Compliance related to monitoring and assurance of Quality Assurance Job Description to include, but not limited to evaluation of programs and effected changes as necessary to improve programs and assure compliance with regulatory requirements. Audits entitled "Resident Oxygen Order Audit" to be performed no later than 2-26-15 by Quality Assurance Coordinator beginning twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter as to ensure residents receiving oxygen administration have active corresponding physician orders and documentation of such in the medication administration record. These audits and	

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F 281	Continued From page 13 the oxygen. Nurse #2 was interviewed on 1/29/15 at 3:49 PM. Nurse #2 stated she remembered the resident and she received continuous oxygen. Nurse #2 stated she would have to review the order for oxygen to remember at what rate Resident #242 received the oxygen. The nurse reviewed the MAR and the TAR and acknowledged there was no order for the oxygen. An interview was held with the Staff Development Coordinator (SDC) on 1/29/15 at 4:00 PM. She stated oxygen was considered a medication and an order was needed for administration. The SDC added orders for continuous oxygen were placed on the MAR. The SDC reviewed the MAR and the TAR and could find no order for oxygen. On 1/30/15 at 11:11 AM, the Director of Nursing (DON) was interviewed. He stated an order was required for oxygen. The DON added oxygen orders were transcribed to the MAR. The DON reviewed the MAR and the TAR and acknowledged there was no order for oxygen for Resident #242.	F 281	findings will be included in the agenda of the quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		2/26/15

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F 309	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, physician interviews and review of medical records, the facility failed to provide on-going respiratory assessments for 1 of 1 sampled residents (Resident # 242) and failed to complete oxygen saturation every shift for 1 week per doctor's orders for 1 of 1 sampled residents (Resident # 242). Findings included: 1. Resident # 242 was admitted on 12/23/14 with an exacerbation of chronic obstructive pulmonary disease (COPD) which had required ventilator support and altered mental status. Review of the Hospital Discharge Summary, dated 12/23/14 indicated COPD with acute exacerbation now resulting in acute respiratory status and intubation, status post extubation. The summary indicated after extubation Resident # 242 was maintained on oxygen received through a nasal cannula. An undated form, titled " Med (Medicare) A Charting Guidelines " with Resident # 242 ' s name, room number and medical record number had identified areas to be addressed in documentation. At the bottom of the form, it was indicated documentation must reflect the condition the resident was treated for in the hospital, including expected complications. Checked on Resident # 242 ' s form included monitor and document lung sounds, pain, shortness of breath, need to have the head of the bed elevated, response to antibiotics, appetite	F 309	Resident #242 noted to be discharged. MDS(Minimum Data Set) nurse #1 to be provided written counseling no later than 2-26-15 by Director of Nursing for failure to obtain written physicians orders for oxygen administration and failure to complete a respiratory assessment for resident #242. Nurse #4 to be provided written counseling no later than 2-26-15 by Director of Clinical Services for failure to transcribe written physician's order for acquisition and documentation of oxygen saturation for resident #242. All licensed nursing staff assigned to resident #242 from 12/23/14 - 12/19/14 to be provided written counseling no later than 2-26-15 by Director of Clinical Services regarding failure to provide on-going respiratory assessments. Facility audit entitled "Respiratory Assessments /Oxygen Admin/Oxygen Saturation Audit to be completed no later than 2-26-15 by Quality Assurance Coordinator as to ascertain Medicare A/ acute episode residents requiring the need for on-going respiratory assessments with the diagnosis of COPD to include, but not limited to, respiratory assessments, oxygen administration, ordered acquisition of oxygen saturation and the documentation of such in the clinical record. In-service training to be completed by 2-26-15 for full time MDS licensed nursing staff conducted by MDS Coordinator regarding MDS assessment accuracy and coding to include, but not	

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F 309	Continued From page 15 and fluid intake, and monitor and document oxygen use and sats (saturations) if ordered. An Admission Nursing Assessment, dated 12/23/14, completed by Minimum Data Set (MDS) Nurse # 1 did not include a respiratory assessment. The assessment indicated the resident was in the facility for short term rehabilitation. Nurse's notes for 12/23/14 at 4:19 PM indicated Resident # 242 ' s oxygen saturation (a measurement of the amount of oxygen carried by blood cells- the level should be 90% or above) every shift times 1 week. The resident was noted as on oxygen continuously through a nasal cannula. A rate of oxygen delivery was not documented. There was no respiratory assessment noted. A physician's telephone order, with a noted by date of 12/23/14 indicated oxygen saturations should be completed every shift for 1 week. Review of the physician's admission orders and the physician's telephone orders failed to reveal an order for the continuous oxygen. Review of the December 2014 Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to reveal an entry for oxygen saturation to be assessed every shift for 1 week. The MAR and TAR did not have an entry for oxygen to be delivered through a nasal cannula. Nurse ' s notes for 12/24/14 at 9:21 PM indicated there were no signs of shortness of breath or dyspnea. There was no documentation of lung sounds. Oxygen saturation was not documented	F 309	limited to, section O. special treatments, procedures and programs per CMS's RAI Version 3.0 manual. In-service training to be completed by 2-26-15 for licensed nursing staff by Staff Development Coordinator to include, but not limited to, the need for physician orders for oxygen administration and saturation with transcription and documentation of such, "Med A Charting Guidelines" usage, and focused COPD respiratory assessment skills via "Silverchair" automated training and/or "COPD Reference Guide to charting"/videos of breath sounds. Written Counseling and in-servicing to be provided to Quality Assurance Coordinator no later than 2-26-15 by Director of Compliance related to monitoring and assurance of Quality Assurance Job Description to include, but not limited to evaluation of programs and effected changes as necessary to improve programs and assure compliance with regulatory requirements. All new admission orders shall be reviewed/audited by Quality Assurance Coordinator within 3 business days of admission on audit tool entitled "Admission/ Re Admission Medical Record Audit" to ensure accuracy of completion of physician orders obtained and transcription of such. Audits entitled "Respiratory Assessment/Oxygen Admin/Oxygen Saturation Audit" to be completed by the Quality Assurance Coordinator twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter as to ascertain Medicare A/acute episode residents	

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F 309	Continued From page 16 for any shift. Review of notes for 12/25/14 at 4:00 PM indicated the nurse had documented " Resp. (respirations) are even throughout " . There was no description of lung sounds. Oxygen saturation was not documented for any shift on 12/25/14. At 11:43 PM, the nurse documented oxygen ongoing as ordered. HOB (head of the bed) up 45 degrees. Nursing notes for 12/26/14 at 3:40 PM indicated respirations were even throughout. Oxygen saturations were not documented for any shift. Lung sounds were not documented as auscultated. The 12/27/14, 5 day Admission Minimum Data Set (MDS) indicated the resident was cognitively intact. Acute respiratory failure was listed as an active diagnosis. Special treatment in the last 14 days, while not a resident, did not include the use of a ventilator. Oxygen was coded as used. On 12/27/14 at 11:59 AM, the nurse's notes indicated the resident had been admitted for weakness and continued on a prednisone (a medication that decreases swelling in the lung tissue) taper for COPD. The resident's respiratory rate was documented as 18. There was no documentation of lung sounds. Oxygen saturation was not coded for each shift. On 12/27/14 at 8:42 PM, the resident's respiratory rate was documented as 18. Oxygen was documented as ongoing as ordered, but there was no rate of administration documented. Oxygen saturation was not documented.	F 309	requiring the need for on-going respiratory assessments with the diagnosis of COPD to include, but not limited to, oxygen administration's written order and transcription, ordered acquisition of oxygen saturation and the documentation of such in the clinical record and monitoring of respiratory assessments. These audits and findings will be included in the agenda of the quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness.	

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F 309	Continued From page 17	F 309		

There were no notes for the 11-7 shift on 12/27/14.

On 12/28/14 at 11:23 AM, a Change in Condition/ER (Emergency Room) note indicated the resident was sent to the ER for evaluation and treatment of respiratory distress. BP was documented as 78/68, Respiration rate 38 and HR 125 to 135. Temperature was 99.3. Oxygen saturation was not documented. Further documentation regarding the 11:23 AM included nurse ' s notes with a time of 12:53 PM that indicated the resident's skin was cold and clammy. Audible wheezes (lung sounds produced when air is squeezed through the air sacs) and rhonchi (coarse lung sounds) in upper lobes. Breath sounds were ausculated and wheezing was noted in the lower lobes. Resident # 242 ' s respiratory rate was documented as 36 and labored. Pulse rate was documented as 125 (normal range 70-100). Oxygen saturation was not documented. The nurse documented the resident left the building at 11:30 AM.

The facility Transfer Form, dated 12/28/14 indicated diagnoses at time of transfer as respiratory distress. Respirations were recorded as 38 per minute and oxygen saturation 99%. BP was 92/44. On the back of the form, the nurse had documented wet lung sounds.

The Hospital History and Physical, dated 12/28/14, indicated the resident presented with shortness of breath 1 hour prior to the transfer.

Resident # 242 ' s physician was interviewed on 1/29/15 at 2:14 PM. She stated if a resident was admitted with respiratory issues she expected an assessment of vital signs every shift for 3 days

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F 309	Continued From page 18	F 309		

and then daily. Additionally, the physician stated, staff were expected to assess the general condition of a resident every shift, which included a respiratory assessment. The physician added if oxygen saturations were ordered and not done, she expected to be notified.

An interview was held with MDS Nurse # 1 on 1/29/15 at 3:16 PM. She acknowledged she had written the admission orders that included oxygen saturation every shift for 1 week. The MDS nurse added it was the responsibility of the nurse on the unit to transcribe, or note, the orders written on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). The MDS nurse added the entry for oxygen saturation should be noted on the MAR. The MDS nurse reviewed the orders and identified Nurse # 4 as the one that signed as transcribing the orders. The MDS nurse reviewed the nurse ' s notes, the MAR and the TAR and acknowledged oxygen saturations had not been documented. She acknowledged respiratory assessments had not been completed.

An interview was held with Nurse # 1 on 1/29/15 at 3:32 PM. Nurse # 1 stated oxygen saturations were documented on the MAR. Respiratory assessments for a resident with any respiratory diagnoses included listening to lung sounds, making sure the resident received the amount of oxygen ordered and keeping the head of the bed elevated. Nurse # 1 added orders were needed to give oxygen since it was a medication. The order included the amount of oxygen a resident received and would be listed on the MAR. Nurse # 1 stated she did not remember if Resident # 242 received oxygen. She reviewed the order for the oxygen saturations and stated she was

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F 309	Continued From page 19	F 309		

unaware of the order. She reviewed the MAR, the TAR and nurse ' s notes and agreed the oxygen saturations had not been recorded. Nurse # 1 reviewed " The Respiratory Guidelines. " She stated these guidelines were posted in the chart and directed the nurses on what to chart for a particular resident. She acknowledged the guideline directed nurses to assess and document lung sounds. The nurse reviewed the nurse's notes and stated she had written the resident ' s oxygen was ongoing on 12/27/14 at 8:42 PM. She added ongoing meant the resident received oxygen continuously. Nurse # 1 could not remember how much oxygen the resident received, did not recall where the order came from and stated she did not know why she had not completed any respiratory assessments for Resident # 242.

Nurse # 2 was interviewed on 1/29/15 at 3:49 PM. The nurse stated the respiratory charting guidelines meant to follow what was checked on the paper when charting. She stated the phrase monitor and document lung sounds meant to listen to the lungs daily and document what the lungs sounded like. Nurse # 2 stated oxygen saturations were be listed on the TAR. Review of the TAR failed to reveal the oxygen saturations. The resident was on continuous oxygen. Nurse # 2 reviewed the MAR, TAR and nurse ' s notes and stated she could find no documentation of oxygen saturations. She had no reason why she had not documented respiratory assessments on the resident, but added she had paid close attention to her. She stated she could not find an order for the amount of oxygen the resident received.

An interview was held with Staff Development

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F 309	Continued From page 20 Coordinator (SDC) on 1/29/15 at 4:00 PM. She stated she was responsible for staff orientation and in-services. The SDC stated during orientation, she spoke about Medicare A charting in general terms. The SDC added the expectation was to include the directions checked on the Charting Guidelines when charting. She added oxygen was a medication that required a physician ' s order that was transcribed to the MAR. The SDC stated oxygen saturations should be included on the TAR. The SDC reviewed the MAR and found no order for oxygen and reviewed the TAR and found no entry for oxygen saturations. An interview was held with the Director of Nursing (DON) on 1/30/15 at 11:11 AM. The DON stated an order was required for oxygen. Oxygen was added to the MAR. The DON stated Charting Guidelines was a reminder of what should be charted for a resident receiving Medicare A benefits. He added that any resident with a respiratory problem should have lung sounds auscultated at least every shift for 72 hours and then daily. The DON added an order for oxygen saturation should be transcribed to the MAR. The DON reviewed nurse ' s notes and stated he found a couple of notes that addressed lung sounds for Resident # 242. He added he did not see a transcription on the MAR or the TAR for oxygen saturations and did not see an order for oxygen. The DON stated he was not sure respiratory assessments or completing oxygen saturations would have made a difference in Resident 242 ' s outcome. The DON added he did see an issue with lack of respiratory assessments.	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		2/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312 SS=D	Continued From page 21 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 and staff interviews and record review the facility failed to remove facial hair for 1 of 1 sampled resident (Resident # 140) observed after receiving care. Findings included: The facility policy titled, " Shaving the Resident " , revised October 2001, indicated the purpose of shaving the resident was to promote cleanliness and to provide skin care. Resident # 140 was readmitted on 3/14/11 with diagnoses that included glaucoma, depression and diabetes. An Annual Minimum Data Set (MDS) with a date of 1/14/15 indicated the resident was cognitively intact. There were no behaviors or rejection of care identified. The MDS coded the resident as requiring extensive assistance with personal hygiene and bathing. The resident's care plan (chart copy), last reviewed 1/19/15, identified Resident # 140 required assistance with activities of daily living. The goal of activities of daily living would be provided daily was to be accomplished with	F 312	Resident #140 shaved by nursing assistant of unwanted facial hair on 1-30-15. Nursing Assistant #4 and 7-3 nursing assistants assigned to resident #64 from 1-28-15 through 1-30-15 responsible for morning grooming care counseled regarding their failure to provide needed service required and requested by resident. Facility-wide canvas of all residents for determination of unwanted facial hair completed 2-9-15 by Quality Assurance Coordinator Assistant for determination of unwanted facial hair. Unwanted facial hair identified removed immediately by assigned nursing assistant staff. If residents refuse removal of facial hair, to be care planned as the resident's choice. Nursing staff to be in-serviced no later than 2-26-15 by Staff Development Coordinator regarding ADL care to include, but not limited to, the removal of unwanted facial hair. Audits entitled "Unwanted Facial Hair Audit" to be conducted by Quality Assurance Coordinator weekly X 1 month, monthly X 1 quarter and quarterly thereafter regarding honoring residents' rights and wishes in removal of unwanted facial hair.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	01/29/2015

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F 312	Continued From page 22 showers on Tuesday and shampoo, shave and nail care as needed. An observation was made on 1/28/15 at 9:30 AM. Nursing Assistant (NA) #2 stated at 9:30 AM she had completed Resident # 140 ' s care for the day. Chin hair was present. An interview was held with Resident # 140 on 1/28/15 at 9:35 AM. She stated NA #2 had not offered to shave her. She stated she would like the chin hair removed. An observation was made on 1/29/15 at 9:35 AM. Chin hair was still present. Resident # 140 had not received her bath. The resident stated NA # 4 was assigned to provide care. NA #3 was interviewed on 1/29/15 at 11:39 AM. The NA stated female residents were to be shaven as needed. The NA added Resident # 140 did not refuse care Resident # 140 was interviewed on 1/29/15 at 11:43 AM. Chin hair was still present. The resident stated NA # 4 had not offered to shave her. She stated NA # 4 had also cared for her on 1/26/15 and had asked if she had a razor. The resident stated that was the last she had heard about getting shaved. Nurse # 3 was interviewed on 1/29/14 at 11:49 AM. She stated female residents should be shaven as needed and shaving should be part of the morning care. The nurse acknowledged Resident # 140 needed to be shaven. On 1/29/15 at 11:56 AM, an interview was held	F 312	Quarterly audits are to be incorporated in the facility's Quarterly Quality Assurance Committee for its membership's review and monitoring of correction of this requirement.	

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F 312	Continued From page 23 with NA # 4. She stated female residents should be shaven as needed with daily care. The NA stated Resident # 140 did not refuse care. The NA added she had not offered to shave the resident although she needed to be shaved. NA # 4 stated she had intended to shave Resident # 140 on Monday, but it had slipped her mind, The Staff Development Coordinator was interviewed on 1/29/15 at 4:20 PM. She stated during orientation, NAs are taught to provide shaving to female residents as needed or when the resident requested.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to implement interventions to prevent falls for 1 of 2 resident reviewed for accidents (Resident # 252). The findings included: Resident # 252 was admitted to the facility on 1/14/2015, with diagnosis to include dementia, post concussive syndrome due to history of recurrent falls, muscle weakness and difficulty walking. His Minimum Data Set assessment, dated 1/28/15 listed his cognitive status as	F 323	Impact mat, magnetic bed/chair alert and non-skid socks provided immediately for resident #252 by nursing staff. Quality Assurance Coordinator to complete canvasing of the facility no later than 2-26-15 by reviewing all residents' charts, care plans and the "FYI" section of the computer charting. These items will be reviewed for current, accurate safety measures listed, to include but not limited to, Impact mats, magnetic bed/chair alerts	2/26/15

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F 323	Continued From page 24 moderately impaired, and his functional status as extensive assistance to total dependence from staff. Physician orders, dated 1/15/2015, ordered impact mat at front side of bed, and magnetic bed/chair alert, check function and placement every shift. A review of the resident ' s Fall Risk Assessment, dated 1/15/2015 was coded with a 14, which represented a High Fall Risk. A review of Resident #252 ' s care plan, dated 1/15/2015, listed as a problem " at risk for falls due to history of multiple falls in past 6 months, use of psychotropic medication, history subdural hematomas, multiple times due to multiple falls, muscle weakness, dementia. Reviewed/continued 1/27/2015. " One of the goals was " no falls with injury x 90 days. " Interventions included, but were not limited to, impact mat at front side of bed, and magnetic bed/chair alert -- check placement and function every shift. A review of the nurse Departmental Notes dated 1/15/2015, stated impact mat at bedside, magnetic bed/chair alert interventions are in place. The note was signed by the Minimum Data Set (MDS) nurse. A second note dated 1/21/2015, stated impact mat at bedside. Magnetic bed/chair alert, placement and function checked every shift. The note was signed by the MDS nurse. A third note dated 1/28/2015, stated impact mat at bedside. Magnetic bed/chair alert, placement and function checked every shift. The note was signed by the MDS nurse. A review of the Nurses Departmental Note dated 1/21/2015 at 10:36 PM stated, when certified nursing assistant (CNA) was feeding resident at meal she noted and reported to me a raised site above right eyebrow area that was 3 centimeters	F 323	and non skid socks/footware. Actual observation of safety measures are to be performed to ensure compliance. Canvasing to be reported on "Safety Measure Audit." Any items found not to be in place are to be implemented immediately by Quality Assurance Coordinator. Nursing department in-services conducted by Staff Development Coordinator no later than 2-26-15 as to ensure protection of residents who are at high risk for falls, instruction for nurses and nurses assistants are to check the "FYI" section of the computer charting each shift for current, new or changed interventions for fall precautions. This instruction to be included with new hire orientation for all nursing staff. These measures are to be maintained throughout the shift. Environmental Services in-services to be conducted no later than 2-26-15 by Environmental Services Director. "House Keeping" and "Floor Tech" staff educated regarding prompt replacement of equipment removed for cleaning/maintenance. Fall mats requiring cleaning are to be replaced with alternate serviceable mat prior to being removed. Audits entitled "Safety Measures" will be preformed by Quality Assurance Coordinator twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter to include, but not limited to, ensuring safety measures are correctly identified in the clinical record, care plans and "FYI" section of the computer charting as well as actual observation of the device in	

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F 323	Continued From page 25 (cm) by 3 cm, and raised greater than 0.5 cm with slight purple appearance. The resident stated to family, CNA and myself at separate times that he was being transferred and the person let go and he fell onto knees and head. Note was signed by the nurse on duty. A review of an Incident/Accident report dated 1/21/2015, at 5 PM, reported that the resident was observed with a 3 centimeter (cm) by 3 cm raised area, raised 0.5 cm, and slightly purple area to right forehead and the resident stated someone was getting him up and dropped him and he went to knees and also bumped head. On 1/27/2015 at 3:52 PM, an observation was conducted in the resident ' s room. The resident was awake and lying on his right side in bed. The back side rail was raised and a blanket covered the resident. No impact mat was observed on the floor or in the room. On 1/28/2015 at 8:23 AM, an observation was conducted in the resident ' s room. The resident was sitting up in a wheelchair, with his clothes on and regular slippers on. No floor mat was observed in the room, and no chair alarm observed on the resident. On 1/28/2015 at 4:28 PM, an interview was conducted with Nursing Assistant #12 (NA #12). NA stated the resident required total care, and he communicated very little. The NA and surveyor walked to the resident ' s room, where the resident, lying in bed, requested orange juice. No impact floor mat was observed in room. The back side rail was up. On 1/29/2015 at 10:51 AM, an interview was conducted with NA #13. NA stated the resident required total care and he had a fall a couple of weeks ago. She stated that she could go to the NA Kiosk in the hall and look up what kind of care each resident required. The NA demonstrated by	F 323	place. Any measures found not to be in place are to be implemented immediately and written counseling of assigned nursing staff completed by Quality Assurance Coordinator. Quarterly audits conducted by Quality Assurance Coordinator and minutes from the monthly falls committee meetings will be incorporated into the quarterly Quality Assurance Committee to ensure ongoing compliance with maintaining of practice of ensuring residents at high risk for falls have appropriate interventions in place. The Quality Assurance Coordinator will monitor.	

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F 323	Continued From page 26 looking up resident #252 ' s information. The Kiosk listed impact mat, bed alert, nonskid foot wear. The NA and surveyor walked to the resident ' s room to see what interventions were in place. The bed alert was attached to the resident, no impact mat was observed in room, and the NA could find only 1 nonskid sock in the resident ' s dresser drawer. On 1/29/2015 at 11:04 AM, an interview was conducted with the Floor Tech. The Floor Tech was placing an impact mat in the resident ' s room. The Floor Tech stated the mats are kept outside in another place. He stated that there was no impact mat in this room before, because the resident hadn ' t been here that long. On 1/29/2015, at 11:07 AM, an interview was conducted with Nurse #3. The Nurse stated that on admission the resident had a fall impact mat, a bed/chair alert and nonskid footwear. She stated that she had just called for an impact mat because the previous one must have gotten misplaced. She stated that she honestly could not remember a date that she saw the floor mat in the resident ' s room. On 1/29/2015 at 12:09 PM, an interview was conducted with the MDS nurse. The MDS nurse stated that she conducted Resident #252 ' s initial assessment the morning after his arrival to the facility. She stated that she ordered the impact mat, and bed/chair alarm, among other interventions on the morning of 1/15/2015, because he was a high fall risk. Interventions with immediate need were to be carried out first. Maintenance would have been called for the mat, and usually the orders were taken care of right away. She stated she did document that the mat was at the bedside, but she did not actually see the mat. The documentation on 1/21/2015 and 1/28/2015 were the dates that the MDS	F 323		

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F 323	Continued From page 27	F 323		

assessments were due, and she had documented the assessments in the resident ' s record. She stated she could not remember seeing the mat in the room, but that it was an intervention, and the order should have been carried out.

On 1/29/2015 at 3:04 PM, an interview was conducted with the Quality Assessment (QA) nurse. The QA nurse stated he was also the Fall Risk Manager for the facility. He stated resident assessments started with the MDS nurse, and she set up the initial interventions. He stated that he and the MDS nurse were responsible to make sure the interventions were in place. If a resident had a fall, the true meaningful intervention was to try and find out the root of the fall. Regarding Resident #252 ' s statement that he fell on 1/21/2015, the QA nurse stated he tried to interview Resident #252 on 1/22/2015, but could not recall if he looked to see if the interventions that were ordered were in place. He stated that even if the interventions that were ordered were not in place, there was a successful outcome because the resident had not had any more falls since 1/21/2015. He stated that taking the residents vital signs, and preforming neuro checks was an intervention. He stated the bed alarm was in place because part of the intervention was to check the placement each shift and the nurses would have documented that on the treatment record. The QA nurse returned with the resident ' s treatment record for January 2015. " Magnetic bed/chair - check function and placement every shift " was listed on the left side of the sheet, and all dates to the right of the sheet were blank.

On 1/30/2015 at 9:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated he expected fall interventions to

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F 323	Continued From page 28 be implemented when the physician order was initiated. He considered a doctor referral, vital signs for 3 days, and monitoring as appropriate interventions. He stated that all nursing staff and all nursing assistant staff check to make sure the interventions are placed.	F 323		
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 observations and staff interview, the facility failed to provide a barrier between residents' ready to eat food and drinking straws touched with the servers' bare hands during 2 of 2 meal observations and a facility cook staff failed to have facial hair covered during food preparation. The findings included: 1. On 01/26/15 at 9:30 am, an observational tour of the facility kitchen and food preparation area revealed the "main cook" had a short full faced beard that was uncovered; he was preparing food on a flat top grill. The main cook indicated that he had never been taught or asked to cover his	F 371	1. "Main Cook" to be counseled/in-serviced by Dietary Manager no later than 2-26-15 regarding policy/procedures as related to facial hair being covered during food preparation. Dietary manager to be counseled/in-serviced by Director of Nursing no later than 2-26-15 related to hair nets or approved hats covering all of the hair must be worn at all times while on duty. All dietary staff to be in-serviced no later than 2-26-15 by the Food Service Manager related to "Personnel Adherence to sanitation Procedures" which includes, but not limited to, hair nets or approved hats, covering all of the hair must be worn	2/26/15

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F 371	Continued From page 29 beard. The main cook indicated his facial hair was short and well groomed. On 01/26/15 at 10:30 am, in an interview with the Dietary Manager (DM) she stated "As long as a beard is short, and close to the skin it is okay not to cover facial hair." 2. On 01/27/15 from 8:00 to 8:30 am, in-room resident dining observations were conducted during the breakfast meal tray service on the "Upper East" resident hall. An observation on 01/27/15 at 8:10 am, revealed Nursing Assistant (NA) #1 picked up a resident's biscuit with bare hands, pulled it apart, buttered and placed it to the side of the resident's plate. The resident self-consumed half of the biscuit. An observation on 01/27/15 at 8:15 am, revealed NA #8 washed her hands, set-up the resident's food tray, picked up the resident's biscuit with bare hands, pulled it apart, buttered and sat the biscuit on the resident's plate and fed the resident. An observation on 01/27/15 at 8:20 am, revealed NA #7 washed her hands picked up the resident's biscuit with her bare hands, pulled it apart, buttered and placed the biscuit on the side of the resident's plate. On 01/27/15 at 8:30 am, an interview with NA #1 indicated NA's were taught by the staff development coordinator (SDC) that handling a resident's food with bare hands was acceptable as long as hands were washed "really good" prior to preparing a resident's food tray including touching a resident's bread, biscuit or ready to eat	F 371	at all times while on duty. New hires and/or agency staff will be in-serviced by Dietary manager regarding "Personnel Adherence to sanitary Procedures" by the food service manager prior to their handling of food as part of their orientation process. Audits entitled "Hair Covering Audits" shall be conducted twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter by the Dietary Manager related to hair nets or approved hats covering all of the hair being worn during the food preparation. These audits and their findings will be included in the agenda of the quarterly Quality Assurance Committee for review and comments by its membership for determination of the corrective action's effectiveness. 2. Nursing Assistant #1, #8, #7, #5, and #6 and additional nursing assistants to be in-serviced by Staff Development Coordinator no later than 2-26-15 related to newly implemented policy to provide a barrier; i.e., plastic wrappers, fork/spoon, between the resident's ready-to-eat food when preparing trays and/or feeding residents. Nursing Assistant #6 and additional nursing assistants in-serviced regarding not touching opened straws with bare hands. A copy of the FDA Food Code obtained by Staff Development Coordinator as related to "hand contact with ready-to-eat foods" and now included in the Educational program for nursing personnel. The Staff Development Coordinator will in-service nursing personnel no later than 2-26-15 related to the FDA Food Code's requirement related	

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F 371	Continued From page 30 food items with bare hands. On 01/27/15 at 8:40 am, an interview with NA #8 indicated that if bread or ready to eat food items were in a food wrapper she would push it out of the wrapper onto the residents plate, but if bread, a biscuit or ready to eat food items were not in a food wrapper it was okay to touch the food item with bare hands to apply condiments as long as hands were washed. On 01/27/15 at 8:45 am, an interview with NA #7 indicated the facility SDC had instructed her if hands were washed prior to setting up a resident's food tray it was acceptable to touch bread, biscuits or ready to eat food items. NA #7 revealed that a barrier was not used when NAs opened and buttered biscuits for residents'. On 01/27/15 at 8:52 am, an interview with the Dietary Manger (DM) indicated that the SDC trained NAs regarding safe serving of food. The DM stated "I would expect that anyone serving food would not touch food items, there must be a barrier between the server and the food item such as a food wrapper or use of utensils. In the kitchen, staff has been trained to wear gloves when bagging food items and to use utensils if they have to move anything around on a food tray." On 01/29/15 at 1:50 pm, an interview with the SDC revealed that she is responsible for all NA education upon employment, orientation and as needed. NAs had been taught by the SDC to wash hands thoroughly prior to handling food. The SDC indicated a break in infection control or disease transmission was not indicated when using bare hands to handle ready to eat food	F 371	to "hand contact with ready-to-eat foods and not touching opened straws with bare hands and to be included with the orientation training of newly hired nursing staff and yearly. Audits entitled "Ready to Eat Food/Drinking Straw Handling Audit" to be conducted by the Quality Assurance Coordinator related to safe handling of ready-to-eat foods and not touching with bare hands opened straws. These audits are to be completed twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly. These audits and findings will be included in the agenda of the Quarterly Quality Assurance Committee meetings for review and comment by its membership for determination of its corrective action's effectiveness. 3. Nursing Assistant #10 and additional nursing assistants to be in-serviced by Staff Development Coordinator no later than 2-26-15 as related to newly implemented policy to not touch residents' bread with her bare hands. Community College's Nursing Assistant program's Director informed of the FDA Food Code related to safe handling of ready-to-eat foods in this facility setting. FDA food code now part of the Staff Development Coordinator's educational program for new hires and yearly in-servicing of nursing personnel. Also, to provide to the Community College a copy of this regulation for its inclusion of its trainees at Smithfield Manor. Nursing personnel to be in-serviced no later than 2-26-15 as related to the FDA Food Code's requirement related to "hand contact with	

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F 371	Continued From page 31 items including biscuits and bread "as long as NAs washed hands thoroughly". The findings included: On 1/26/2015 at 12:45 PM, a dining observation was conducted on the 200 Hall. Nursing Assistant #5 (NA #5) was observed taking residents bread out of the paper wrapper with her bare hands and placing it on the resident ' s lunch tray in room 212. On 1/26/2015 at 12:48 PM, Nursing Assistant (NA #6), was observed serving residents in rooms 215 and 226, by taking the bread out of paper wrapper with her bare hands and placing on the residents lunch tray. In room 221, NA #6 took the resident ' s bread out of the paper wrapper and placed it on the resident ' s lunch tray with her hand. She then opened the residents straw from the paper wrapper and touched the drinking end of the straw. On 1/27/2015 at 12:40 PM, NA #6 opened the straw for the resident in room 205 and touched the drinking end of the straw. On 1/27/2015 at 9:47 AM, NA #5 was interviewed. NA#5 stated she had received yearly in-service training on serving residents trays, but does not remember when the last training was. Stated she usually took the bread out of the wrapper and placed it on the resident ' s tray with her hand. On 1/27/2015 at 1:46 PM, an interview was conducted with NA #6, who stated that she had received an in-service training in the past year on passing residents trays. She stated she usually opens the bread package and tries to slide out the bread without touching it. When NA #6 was questioned by the surveyor on why she touched	F 371	ready-to-eat foods" by Staff Development Coordinator and to be included with the orientation training of newly hired nursing staff and then yearly and/or as needed. Audits entitled "Ready to Eat Food/Drinking Straws Handling Audit" to be conducted by the Quality Assurance Coordinator twice weekly X 1 week, weekly X 1 month, monthly X 1 quarter and quarterly thereafter related to safe handling of ready-to-eat foods. These audits and findings will be included in the agenda of the quarterly Quality Assurance Committee meeting for review and comment by its membership for determination of its corrective action's effectiveness.	

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	345175	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

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F 371	Continued From page 32 the bread in 3 residents ' rooms, and the straw ends in 2 rooms, she stated that she doesn ' t think all the time, and she had gotten nervous that someone was watching her. On 1/28/2015 at 4:19 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated that she was the educator for the facility and she had conducted in-service training for the nursing assistants (NA). She stated the expectation was for the NA to wash their hands before passing trays, touching food or the ends of the straws. She stated it was never the expectation that the NA would not touch the food or straws with their bare hands. On 1/29/2015 at 1:52 PM, a second interview was conducted with the SDC. She stated she was not familiar with the food handling code specifics, and still could not understand why it was not okay to touch the food after hand washing. On 1/29/2015 at 4:01 PM, the Quality Assurance (QA) nurse was interviewed. The QA nurse stated that he had observed the NA ' s passing meal trays on Nov 3, 2014 and Nov 4, 2014. He stated that he only observed the NA for hand washing, and did not observe for food handling. He stated he was not familiar with anything to do with handling the food. 3. On 1/26/15 at 12:34 PM, Nursing Assistant (NA) # 10 was observed serving a meal to the resident in Room 404. The NA placed the tray on the over bed table. As she was unwrapping the food items, she used her left hand to hold the bag that contained the sliced bread. With her right hand, she touched the bread and placed it on the resident ' s plate.	F 371		

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F 371	Continued From page 33 An interview was held with NA # 10 on 1/28/15 at 3:10 PM. The NA stated she had been taught to wash her hands, open the tray items and taught to not handle the food items with her bare hands. The NA stated she did not remember handling the resident ' s bread. The Staff Development Coordinator (SDC) was interviewed on 01/29/2015 at 1:52:24 PM. The SDC stated the information taught to the NAs during orientation came from a book used by the community college for NA classes. Online classes are also used for staff instruction. She stated staff monitored hand-washing and food tray delivery. The SDC stated she was not familiar with the food code. The SDC added the facility was supposed to be a home environment, and touching food was done in the home and stated she did not understand why it was not acceptable to touch food in the facility.	F 371		
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.	F 411		2/26/15

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F 411	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to arrange routine dental care for 1 of 2 sampled residents (Resident # 140) reviewed for dental care. Findings included: Resident # 140 was readmitted on 3/14/11 with diagnoses that included diabetes, glaucoma and depression. Review of Resident #140 ' s medical record indicated the consent for dental treatment was signed on 5/1/09. There was no evidence Resident # 140 had received a dental consult found in her medical record. The 8/29/14, Registered Dietician (RD) note indicated Resident # 140 had lost 14 pounds or 9% in 3 weeks. The resident's dental status was not addressed. A general nurse ' s note for the annual assessment, dated 1/14/15 at 12:16 PM, indicated Resident #140 required extensive assistance with bathing and hygiene. The note indicated the resident had no upper teeth and just a few of her own lower teeth. An Annual Minimum Data Set (MDS) with a date of 1/14/15 indicated Resident # 140 had no broken natural teeth, no problems with dentures and no problems chewing.	F 411	Resident #140 received a dental exam by facility dentist on 2-12-15. All residents to be canvased via a facility-wide-audit entitled "Needed Dental Visits" no later than 2-26-15 by the Quality Assurance Coordinator Assistant to determine compliance/current status with the regulation pertaining to yearly dental exams by a dentist and to further determine a schedule for all existing residents to ensure their being offered dental services annually. Facility dentist scheduled to perform dental exams no later than 2-26-15 on all residents deemed delinquent. MDS(Minimum Data Set) personnel to be counseled no later than 2-26-15 by Director of Nursing regarding their inaccuracy of Section L. Oral/Dental status of resident #140. MDS personnel to be in-serviced by MDS Coordinator no later than 2-26-15 regarding accuracy of the MDS assessments. Quality Assurance Coordinator will develop a schedule no later than 2-26-15 to ensure all newly admitted residents are offered dental visits within the first year of admission and annualy or upon any newly discovered acute dental symptoms. This schedule will be included in the agenda of the Quality Assurance Committee quarterly meetings for its membership to monitor and determine compliance.	

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F 411	Continued From page 35 The Annual RD Assessment, dated 1/15/15 at 3:37 PM indicated Resident # 140 received a mechanical soft diet. Dental status was not addressed in the note. Review of Resident #140 ' s care plan, last reviewed 1/19/15, did not address dental issues. The Quality Assurance (QA) Nurse was interviewed on 1/29/15 12:01 PM. The QA nurse stated he helped coordinate dental appointments. A dentist visited the facility once a month. Referrals for dental appointments were received from the MDS nurse, the Admissions specialist and nursing staff. The QA nurse added family members or residents could also refer. The QA nurse stated the goal was for all residents to be seen every 6 months for a basic evaluation. He added documentation from the dentist consultation was filed in the resident's chart under consult. At 1:36 PM, the QA nurse stated he was " off " about how dentist referrals were made. The QA nurse stated MDS nurse evaluated residents and referred residents to be seen by the dentist on a case by case basis. He added he could not verify all residents were seen. The QA nurse was interviewed on 1/29/15 at 2:00 PM. He stated Resident # 140 had not been seen by a dentist since her 2011 re-admission. The QA nurse added based on his observation of Resident #140 ' s broken teeth, she needed to be seen by the dentist. The QA nurse stated he had spoken to the Administrator and they were working on the system to correct this issue.	F 411		