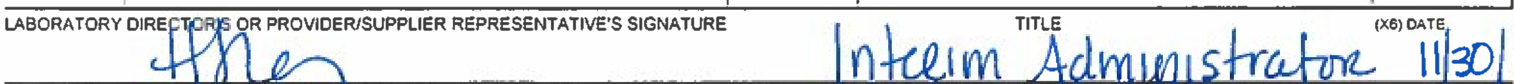
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete a significant change Minimum data Set (MDS) for 1 of 1 (Resident # 27) reviewed for hospice services. Findings Included: Resident #27 was admitted on 11/27/14. The resident had a cumulative diagnoses of stroke with left sided weakness, aneurysm, aphasia (difficulty speaking) due to stroke, dysphagia, dementia, hypokalemia, anorexia, anxiety, weakness, urinary tract infection, anemia and seizures. A record review of the quarterly MDS dated 9/24/15 revealed the resident was severely cognitively impaired with no behaviors. Resident #27 was an extensive assist with assist of two	F 274	A significant change assessment will be completed for Resident #27 to capture the hospice status. All residents who elect hospice have the potential to be affected. The MDS coordinator will attend daily clinical meetings where all orders are reviewed. When there is an order for a resident to be admitted to hospice, the MDS coordinator will note it and open a significant change assessment and complete it within required timeframes. The MDS coordinator will be educated on the requirement to complete a significant change MDS for any resident who elects hospice. The DON/designee will audit 100% of all residents currently on hospice to ensure that significant change assessments were done. Any missing assessments will be completed and submitted. The DON/designee will continue to audit 100% of all residents admitted to hospice monthly for significant change MDS completion monthly for 3 months. Results of the audits will be reported to the QAPI committee for review.	12/4/15

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



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 274	Continued From page 1 with bed mobility and transfers, extensive assist with assist of one with dressing, toileting and hygiene, limited assist with meals and total dependence with one assist for bathing. The resident used a walker and a wheelchair and had no impairments. The resident was always incontinent of bowel and bladder. The life expectancy of 6 months or less was recorded as " no " on this MDS quarterly review. A record review revealed the resident had the following plans of care updated on 8/16/15: Activity of daily living (ADL) deficit related to hemiplegia due to stroke, a communication problem related to effects of stroke/aphasia, high risk for falls related to hemiplegia, aphasia and weakness, a nutrition care plan and a hospice care plan. A record review of the Physician ' s certification for Medicare Hospice benefit revealed the resident had a history of a stroke and seizures with poor oral intake and refused feeding tube. The Medical Director ' s certification was signed on 8/7/15 to give consent for Resident #27 to receive hospice services based on his diagnosis of a chronic progressive illness with a life expectancy of six (6) months or less. A record review revealed a nurse and the Chaplain saw Resident #27 on 11/3/15 at 11:56 am. During an interview with Nurse #1 on 11/4/15 at 10:15 am, she revealed the resident was alert and oriented to self. He is on hospice due to a decline in his health. The nurse added the hospice staff visits the resident once per week with the exception of the chaplain who visits almost every day. The nurse reported the CNA ' s at this facility do the daily care and activities for	F 274		

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F 274	Continued From page 2 daily living for this resident when the hospice team is not at the facility. During an interview with the MDS Coordinator on 11/4/15 at 12:58 pm, she revealed that the expectation was to have a significant change status updated in the MDS when a resident was started on hospice. The MDS Coordinator added that she should have updated the MDS with this significant change. During an interview with the Director of Nursing on 11/5/15 at 1:25 pm, revealed her expectation of the MDS Coordinator was to update the MDS when there are significant changes to our residents.	F 274		
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 interviews and record reviews, the facility failed to administer a prescribed supplement in the right dose 6 out of 10 days for 1 of 1 resident (Resident #44). Findings Included: A record review of Resident #44 revealed the resident was admitted on 6/16/15. The resident had diagnoses of dementia, failure to thrive and Parkinson ' s disease. A record review of the quarterly Minimum Data	F 281	The MAR was corrected for resident #44 to reflect the accurate order for 120 milliliters three times daily, and the resident has been receiving the correct amount since November 5, 2015. All residents with supplement orders have the potential to be affected. The DON/designee will review all current supplement orders to ensure accurate transcription to the MAR The dietician will recommend to the physician orders for all supplements as needed. The nurse who takes off the order will transcribe the order for the supplement onto the MAR. The nurses will be educated on the requirement to transcribe orders timely and accurately to the MAR, as well as the process for ensuring orders carry over from month to month on the MAR.	12/4/15

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F 281	Continued From page 3 Set (MDS) dated 9/23/15 revealed the resident was severely cognitively impaired. The resident required extensive assist with Activities of Daily Living (ADL's). A record review of the care plans revealed the resident had a nutritional care plan in place, which included: Nutrition related to progression of Parkinson ' s disease state. Interventions included providing supplements as ordered, provide diet as ordered and document consumption and behaviors. A record review of a nutrition note written by the Dietician on 10/27/15 revealed the resident had a significant weight loss of 8 pounds or 5% in one month. The recommended intervention was to increase the current nutritional supplement from 60 milliliters to 120 milliliters three times per day, weekly weights for 4 weeks and to monitor intake of meals. A record review revealed a physician ' s order was written on 10/27/15 to increase the nutritional supplement from 60 milliliters three times per day to 120 milliliters three times per day. The order was transcribed to the October Medication Administration Record (MAR) on 10/27/15 but it was noted that it began on 10/29/15 instead of the original order date of 10/27/15. An interview with Nurse #1 on 11/4/15 at 3:15 pm revealed the nurse reported the new order should have started on 10/27/15 as written by the physician. The resident received only 60 milliliters three times per day on 10/27/15 and 10/28/15 instead of 120 milliliters as ordered. The nurse did not know why it started on 10/29 when the order was written on 10/27. Nurse #1	F 281	The DON/designee will review all new orders for supplements on business days. She will audit 75% of the corresponding MAR's for one month, 50% the second month and 25% for the following month. After the first of the month, the DON/designee will audit 75% of the MAR's for residents with supplements to ensure that the orders were carried over from month to month, 50% the second month and 25% the third month. Results of the audits will be reported to the QAPI for review.	

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F 281	Continued From page 4 further stated that on 10/29/15 thru 10/31/15 the resident began to receive the 120 milliliters as ordered. However, the order was transcribed to the November MAR as 60 milliliters three times per day instead of 120 milliliters three per day. A record review revealed the nutritional supplement order on the November MAR was transcribed as 60 milliliters three times per day. The 60 milliliters was signed off as given by the nurse each day three times per day on 11/1, 11/2, 11/3, and two times on 11/4/15. The physician ' s order dated 10/27/15 revealed the resident should have been getting 120 milliliters three times daily. An interview was conducted with the Dietician on 11/5/15 at 1:48 pm. She revealed her expectation was for the resident to receive the supplement as ordered per the physician ' s order sheet and to document in the MAR that it was given or refused by the resident. An interview with the Director of Nursing on 11/5/15 at 11:45 am revealed her expectation was for nurses to administer all prescribed orders as they were ordered by the physician. Additionally, her expectation was for the nurses to ensure accurate transcription of all physician orders.	F 281		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	(Note: Statement of deficiencies cites resident number 32. Based on conversations held between staff and surveyors, this should be resident 36.)	

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F 318	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and record reviews, the facility failed to apply splints for 2 of 5 residents with contractures (Resident #2 and 32). Findings included: 1. Resident #2 was admitted on 12/7/14. The diagnoses included diabetes, cerebral vascular disease, respiratory distress and left hand contracture. The most recent Minimum Data Set (MDS), dated 9/18/15, revealed the resident was severely cognitively impaired. The resident required total assistance with the activities of daily living. Review of the physician ' s order dated 11/28/14, revealed a palm roll was to be applied every morning and worn 7:00AM to 5:00PM and reapplied as needed. The Plan of Care for resident#2 dated 10/2/15, indicated that the resident had an alteration in musculoskeletal status related to multiple contractures. The goal included the resident would not develop new contractures and pain from contracture would be managed. The approach included the encouragement of the resident to allow staff to put on the splint as ordered. Apply the palm roll splint to left hand every morning at 7am and off 5pm." Review of the restorative mobility documentation undated, revealed Resident #2 hand a left	F 318	Occupational therapy will screen residents #2 and #36 to determine what devices, if any, are appropriate for the current condition of the residents related to range of motion management. The orders will be changed as necessary to reflect the current recommendations. The care plans of these residents will be updated to reflect the current recommendations. All residents with orders for splints have the potential to be affected. The DON/designee will assess each resident to ensure that all contractures are identified. Occupational therapy will screen those residents identified with contractures and make recommendations for splint/device usage. Orders will be recommended by OT to the physician or current orders verified as appropriate and transcribed to the TAR. CNA's will apply and remove splints per order. The nurses will monitor splint application and usage and document such on the TAR. Care plans will be updated as needed. CNA's will be educated on the proper use of splints and contracture management devices. Nurses will be educated on the need to monitor application of same. The DON/designee will monitor for proper usage and documentation of devices for 75% of residents with orders for one month, 50% for the second month and 25% for the third month. Results of the audits will be submitted to the QAPI committee for review.	12/4/15

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F 318	Continued From page 6 contracture that required the use of a mitt splint. The goal included the resident would tolerate the splint on the 4th digit for 4 hours without signs and symptoms of redness. During an observation on 11/2/15 at 11:40AM, there was a beige splint located on the tray table. Resident #2 was in bed watching television. During an observation on 11/3/15 at 9:40AM, the beige splint was located on the tray table across the room. During observation on 11/3/15 at 10:40AM, the splint remained on the tray table across the room. During an interview on 11/3/15 at 12:37PM, the family member indicated the splint was inconsistently placed on the resident. The family member further stated that staff did not seem to know when the splint should be on or off, most of the time during visits the splint was off and on a table somewhere in the room. During an observation on 11/3/15 at 12:37PM, Resident #2' s left hand was contracted and the splint was lying on the tray table across the room. During an observation on 11/4/15 at 8:42AM, the splint was lying on a pillow on top of a laundry basket. During an interview on 11/4/15 at 8:50AM, NA#2 indicated that the resident was unable to feed herself but able to hold cup. The restorative aide was responsible for applying the splint. NA#2 confirmed the splint lying on the pillow on top of the laundry basket.	F 318		

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F 318	Continued From page 7 During an interview on 11/4/15 at 8:50AM, RA/NA#3(restorative aide) indicated that she was responsible for applying splints on residents daily. NA#3 indicated when she was pulled to the floor to perform other duties she does not always get around to applying all the residents ' splints as ordered. She confirmed she had not applied the resident's splints. She further stated that she did not have a place to document the time when the splint was applied or removed. During an interview on 11/4/15 at 9:30AM, Nurse #2 indicated that the rehabilitation department was responsible for overseeing the restorative program. The restorative aide was responsible for applying the splints as ordered. She indicated that the restorative aide' s responsibilities had changed and she was needed more on the floor as a nursing assistant. The rehabilitation director and Director of Nursing (DON) was responsible for overseeing whether the splint application was maintained. During an interview on 11/4/15 at 10:00AM, the rehab director indicated the DON was responsible for overseeing restorative program. Once the resident was discharged from therapy nursing assumed the restorative care for the resident. During an observation on 11/5/15 at 8:45AM, the splint was lying under a pile of clothing on the laundry basket. During an interview on 11/5/15 at 9:15AM, the administrator indicated the expectation was for staff to apply the splint as ordered. She acknowledged the resident's order for the splint had not been discontinued. She added that staff was responsible for documenting the time when	F 318		

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F 318	Continued From page 8 the splint was applied and removed. During an interview on 11/5/15 at 2:21PM, the director of nursing (DON) indicated the expectation was for the restorative aide to apply the splints as ordered. The DON confirmed the restorative aide had not been consistent with the application of the splints due to other responsibilities as nursing assistant. 2. Resident #32 was admitted on 10/13/13. The diagnoses included dementia, contracture of elbow, osteoporosis, contracture of hand joint and convulsions. The recent Minimum Data Set (MDS) dated 9/7/15, indicated that Resident #32 ' s cognition was impaired and required total assistance with activities of daily living. Review of the physician ' s orders 10/5/15, revealed the elbow extension splint was to be worn 8 hours to decrease the risk of contraction. The Plan of Care for resident #32, dated 11/4/15, indicated the resident had limited physical mobility related to contractures and dementia. The goal included the resident would be moved by staff through next review. The approaches included staff would provide skin care to prevent skin breakdown, nursing/restorative splint/brace apply per orders, monitor and document any signs and symptoms of immobility, contractures forming worsening and thrombus formation. Review of the restorative mobility documentation form dated 5/20/14, revealed Resident #32 ' s splint application included hip/knee bolster and an elbow extension splint. The goal included the resident would tolerate passive range of motion (PROM) to legs for placement of knee bolster and	F 318		

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F 318	Continued From page 9 PROM to left elbow for placement of splint. Resident would tolerate knee bolster for 8 hours and elbow extension splint for 8 hours with no s/s of skin breakdown or redness During an observation on 11/2/15 at 11:32AM, Resident #32 had a blue splint on her left elbow/hand and a pillow under legs. This hip bolster was not in place. During observations on 11/3/15 at 10:40AM, the blue elbow splint was on the side table. During an observation on 11/3/15 at 12:37PM, resident lying in bed and the blue splint was lying on the side table behind the resident. During an observation on 11/3/15 at 3:30PM, resident in bed and splint on side table behind resident. During an observation on 11/4/15 at 8:42AM, the resident ' s blue elbow splint was lying on the side table in the corner. During an interview on 11/4/15 at 8:50AM, RA/NA#3(restorative aide) indicated that she was responsible for applying splints on residents daily. NA#3 indicated when she was pulled to the floor to perform other duties she does not always get around to applying all the residents ' splints as ordered. She confirmed she had not applied the resident's splints. She further stated that she did not have a place to document the time when the splint was applied or removed. During an interview on 11/4/15 at 9:30AM, Nurse #2 indicated that the rehabilitation department was responsible for overseeing the restorative	F 318		

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F 318	Continued From page 10 program. The restorative aide was responsible for applying the splints as ordered. She indicated that the restorative aide ' s responsibilities had changed and she was needed more on the floor as a nursing assistant. The rehabilitation director and Director of Nursing (DON) was responsible for overseeing whether the splint application was maintained. During an interview on 11/4/15 at 10:00AM, the rehab director indicated the DON was responsible for overseeing restorative program. Once the resident was discharged from therapy nursing assumed the restorative care for the resident. During an observation on 11/4/15 at 11:00AM, the blue elbow splint was on the side table under pile of clothing. During an observation on11/4/15 at 2:20PM, the blue elbow splint remained under a pile of clothing. During an observation on 11/5/15 at 8:45AM, the blue elbow splint was lying under a pile of clothing on the side table. During an interview on 11/5/15 at 9:15AM, the administrator indicated the expectation was for staff to apply splints as ordered. She acknowledged the resident's order for the splint had not been discontinued. She added that staff was responsible for documenting the time when the splint was applied and removed. During an interview on 11/5/15 at 2:21PM, the director of nursing (DON) indicated the expectation was for the restorative aide to apply the splints as ordered. The DON confirmed the	F 318		

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F 318	Continued From page 11 restorative aide had not been consistent with the application of the splints due to other responsibilities as nursing assistant.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to obtain the resident ' s weight per dietary recommendations due to significant weight loss 1 week out of 4 weeks for 1 of 1 resident (Resident #44). Findings Included: A record review of Resident #44 revealed the resident was admitted on 6/16/15. The resident had diagnoses of dementia, failure to thrive and Parkinson ' s disease. A record review of the quarterly Minimum Data Set (MDS) dated 9/23/15 revealed the resident was severely cognitively impaired. The resident required an extensive assist with all Activities of	F 325	Resident number 44 will be weighed per the most recent recommendation of the dietician. The care plan has been updated to include the need to weigh the resident per protocol. The resident has been receiving the correct supplement dosage since November 4, 2015. All residents with weight loss have the potential to be affected. The DON/designee will audit the medical records of all residents with weight loss to ensure that weights are done per recommendation/protocol and other recommendations of the RD have been implemented.. Any deficiencies identified will be corrected. The dietician will review all weights at least monthly. She will recommend changes to the plan of care including supplements and weight frequency per her discretion. She will document her recommendations in the form of a progress note and will communicate her recommendations to the nursing department. The dietician will recommend to the physician orders for supplements. She will provide a list of residents to be weighed weekly to the DON/designee. The dietician will review these weights weekly and request further weights as needed. In the event that a weight has not been obtained per protocol, the dietician will notify the DON/designee who will in turn ensure that the weight is obtained. All weights will be documented electronically in the resident's medical record. The dietician/designee will update care plans of residents with weight loss to include interventions for weights.	12/4/15

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F 325	Continued From page 12 Daily Living (ADL's). A record review of the care plans revealed the resident had a nutritional care plan in place, which included: Nutrition related to progression of Parkinson ' s disease state. Interventions included providing supplements as ordered, provide diet as ordered and document consumption and behaviors. There was no care plan in place regarding the weight loss for this resident. A record review of a nutrition note written by the Dietician on 10/27/15 revealed the resident had a significant weight loss of 8 pounds or 5% in one month. The recommended intervention was to increase the current nutrional supplement from 60 to 120 milliliters three times per day, weekly weights for 4 weeks and to monitor intake of meals. A record review of the resident ' s weights revealed the following: 6/21 167 6/22 165 7/9 166 7/13 164 9/18 158 10/16 146 10/27 149 A record review revealed a physician ' s order was written on 10/27/15 to increase the nutritional supplement from 60 milliliters three times per day to 120 milliliters three times per day. The order was transcribed to the October Medication Administration Record (MAR) but it was noted that it began on 10/29/15 instead of the original	F 325	CNA's will be educated on the requirement to obtain weights upon the recommendation of the dietician and/or protocol. The dietician/designee will audit 75% of residents with recommendations for weekly weights to ensure that they are completed for one month, 50% for the second month and 25% for the third month. Results of the audits will be submitted to the QAPI committee for review.	

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F 325	Continued From page 13	F 325		

Continued From page 13

order date of 10/27/15.

An interview with Nurse #1 on 11/4/15 at 3:15 pm revealed the nurse reported the new order should have started on 10/27/15 as written by the physician. The resident received only 60 milliliters three times per day on 10/27/15 and 10/28/15 instead of 120 milliliters as ordered. The nurse did not know why it started on 10/29 when the order was written on 10/27. Nurse #1 further stated that on 10/29/15 thru 10/31/15 the resident began to receive the 120 milliliters as ordered. However, the order was transcribed to the November MAR as 60 milliliters three times per day instead of 120 milliliters three per day.

A record review revealed the nutritional supplement order on the November MAR was transcribed as 60 milliliters three times per day. The 60 milliliters was signed off as given by the nurse each day three times per day on 11/1, 11/2, 11/3, and two times on 11/4/15. The physician ' s order dated 10/27/15 revealed the resident should have been getting 120 milliliters three times daily.

An interview with Nursing Assistant/Restorative Aid (N/A/RA) #4, on 11/05/2015 at 11:06 am revealed the resident consumed 75% of his breakfast and 25% of his lunch. NA #4 reported she had this resident for the past 3 days (11/3, 11/4, and 11/5). She reported the resident gets monthly weights. The NA reported she was not aware he was supposed to get weekly weights for 4 weeks.

An interview with the Dietician on 11/5/15 at 2:44

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F 325	Continued From page 14 pm revealed when there is a dietary order she was instructed by the Director of Nursing and the Administrator to not write dietary orders in the Physician Order Sheets. The Dietician honored this request and said she spoke with one of the restorative aids who manage the weights and informed her verbally that she needed weekly weights for 4 weeks for this resident. She further added the weight book is kept in a binder at the nurse ' s station for the NA ' s to know who needs to be weighed. A record review of the weight book at the nurse ' s station revealed there was no indication that this resident was to have weekly weights for four weeks. The weight book was reviewed with the Dietician. An interview with Nurse #4 on 11/05/2015 at 3:26 pm revealed the Resident #44 is not listed to have weekly weights on the MAR. The nurse reported he is weighed monthly. Nurse #4 reported she was not aware this resident was supposed to be weighed weekly for 4 weeks. Observation of resident on 11/5/15 at 3:30 pm revealed Resident #44 sitting in his wheelchair self -propelling in the halls. An interview with the Administrator on 11/5/15 at 3:55 pm revealed that her expectation was for the NA ' s and RA ' s to follow the dietary recommendations and obtain the Resident ' s weights as requested. The Administrator further added that she expects the staff to monitor the resident ' s weights and inform the nurses of any significant weight changes. The Administrator confirmed that she requested the Dietician not to write dietary orders on the Physician Order	F 325		

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F 325	Continued From page 15 Sheets.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and record reviews, the facility failed to provide podiatry care for 1 of 1 residents that required specialty foot care (Resident #48). The findings included: Resident #48 was admitted to the facility on 1/7/13. The diagnoses included dementia, diabetes, neuropathy and congestive heart failure. The Minimum Data Set (MDS) dated 9/7/15, indicated the resident was cognitively impaired and required total assistance with all activities of daily living. The care plan dated 9/19/15, identified the problem as activities of daily living (ADL) self-care performance deficit related to immobility. The goal included resident would be comfortable and	F 328	The toenails for resident #48 were cut. All residents with toenails have the potential to be affected. The toenails of all residents will be assessed by the DON/designee to determine if nail care can be done by nursing staff or if the services or a podiatrist are required. The nursing staff will provide toenail care for residents for which it is appropriate. Appointments will be made for residents who require podiatry care per consent of the responsible party. CNA's will monitor the condition of residents' toenails during bathing. The CNA will provide toenail care as they are able and will refer to the nurse those residents for which they cannot provide nail care. The nurse will provide nail care for those residents for which she is able. In the event that the resident requires professional podiatry care, the resident will be referred to a podiatrist. Nursing staff will be educated on proper toenail care and the need to monitor and report any abnormalities. The DON/designee will assess the toenails for proper nail care of 75% of residents for one month, 50% for the second month and 25% for the third month. Results of the audits will be reported to the QAPI committee for review.	

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F 328	Continued From page 16 cared for through next review. The approach included the provision of daily skin care and to prevent skin break down. During family interview on 11/3/15 at 2:42PM, the family member indicated that Resident #48 ' s foot care was very poor. She indicated that the toe nails were very thick and long and they needed to be cut. The family member stated that had spoken with the staff about the condition of the resident ' s toe nails and nothing had been done nor had the resident been referred for outside care. During an observation on 11/4/15 at 1:00PM, the therapist was performing range of motion exercise to the resident ' s lower legs and ankles. The big toe nails on both feet were very thick with 1 inch past the toe. The other toe nails were very thick and discolored. During an observation on 11/5/15 at 8:27AM, NA#7 confirmed the toe nails were very thick and discolored, long and sharp. The NA further stated that nursing staff cut the toe nails for diabetic residents and the NA did routine toe and nail care for other residents. She further stated she had not cut the resident ' s toe nails. During an observation on 11/5/15 at 9:07AM, Nurse #4 checked the resident ' s toe nails and indicated that they were thick, yellow and long. The condition of the feet were dry and cracked. She further stated the resident could benefit from being seen by the podiatrist. During an interview on 11/5/15 at 9:10AM, the unit secretary indicated that she was the responsible person for scheduling podiatry	F 328		

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F 328	Continued From page 17 services. She further stated that when nursing and/or family make a request for outside services, she would set up the appointment. She was unaware of the nursing staff or family request to schedule a podiatry appointment. During an interview on 11/5/15 at 9:14AM, the Administrator indicated the expectation was for nursing to attempt to cut the toe nails of the diabetic residents. If they were unable the resident would be referred to a podiatrist. The condition of the finger nails and toe nails should be checked daily and a referral should be made when they were unable to cut them during routine care. During an interview on 11/5/15 at 9:28AM, NA#3 indicated that the NA did not cut the residents ' toe nails that were diabetics. The nursing staff was responsible for cutting r residents ' toe nails. She further indicated that she could not recall when this resident ' s toe nails were last cut. During an interview on 11/5/15 at 10:12AM, the director of nursing (DON) indicated that the expectation was for NA/nursing to complete the CNA shower skin observation tool to indicate the condition of the resident ' s skin, finger/toe nails. She indicated that NAs would cut the nails/toe nails during the normal routine care, however, if the diabetic residents ' toe nails needed to be cut the expectation was for the nursing staff to attempt. If the nurse was unsuccessful then the resident would be referred to an outside podiatrist. The nurse was responsible for giving the information to the unit secretary/scheduler.	F 328		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		

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F 334	Continued From page 18 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	Residents #7, 16, 24, and 36 will be offered education and the opportunity to elect or decline the pneumococcal vaccination. The medical record will be updated to include administration or declination. Resident #19 was discharged home. All residents have the potential to be affected. The DON/designee will audit all medical records to determine if education was provided and administration or declination is documented in the medical record. Upon admission all residents will be offered the opportunity to receive or decline the pneumococcal vaccination after education is provided. This will be documented in the medical record. Nurses will be educated on the requirement to educate, offer and document the vaccinations. The DON/designee will audit 75% of the medical records of new admissions for one month, 50% for the next month and 25% of the following month.	12/4/15

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F 334	Continued From page 19 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to offer pneumococcal immunization to 5 of 5 sampled residents (Residents #7, #16, #19, #24 and #36). Findings included: A review of medical records for Residents #7, #16, #19, #24 and #36 was conducted. No pneumococcal documentations were available for review. There was no documentation that	F 334		

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pneumococcal vaccine was offered or administered.

An interview was conducted on 11/05/2015 at 3:00 pm with the Director of Nursing (DON). She acknowledged she was unable to locate the Influenza and Pneumonia screening questionnaire (a form offered at admission that included the option for the resident to decline or accept the vaccines). The DON was not able to locate the pneumococcal immunization records (a form that indicated if the resident declined or accepted the vaccine and if it was administered) for Residents #7, #16, #19, #24 and #36, as they should have been included in the residents ' records.

An interview was also conducted with the Administrator on 11/05/2015 at 3:22 pm. She stated that the admission packet which was given to all residents and responsible party contained the Influenza and Pneumonia screening questionnaire. The questionnaire included the option to decline or accept the immunization. She stated she had made every effort to keep the resident's and responsible party informed about their rights. The Administrator further indicated that her expectations were for the Pneumococcal immunization to be offered to residents and or the responsible party upon admission. If the resident accepted, her expectations were for the nurses to administer the immunization accordingly, and the documentation filed in the resident 's record.

F 371 SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY F 371

The facility must -
(1) Procure food from sources approved or

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F 371	Continued From page 21 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, staff interviews and record review, the facility failed to maintain sanitary conditions in the kitchen by 1) ensuring that fresh produce was removed from spoiled/rotten produce in 2 of 2 walk in refrigerator, 2) discarding opened unlabeled/undated foods in 1 of 2 walk in refrigerator, 3) cleaning the hot plate cart, 4) cleaning dry storage bins, 5) failing to air dry serving pans and clean and removing the trash from the flooring for 2 of 2 refrigerators. The findings included: 1. During an observation of the kitchen on 11/2/15 at 9:25AM, 2 of 2 walk in refrigerators had the following items: 1 crate of rotten/molded strawberries, 1 box of fresh ginger with mold and fungus, 2 boxes of mini green peppers were molded/ rotten, 1 box of red peppers molded/ rotten, 1 box of squash molded/rotten and box of lettuce that was brown and wilted in packages, During an interview on 11/2/15 at 9:25AM AM, the dietary aide and dietary manager (DM) indicated the fresh produce should be checked when delivered and the spoiled/rotten produce should be discarded. Dietary Manager indicated that he	F 371	The affected produce was discarded at the time of identification. The unlabeled food was either discarded or labeled as appropriate at the time of identification. The hot plate cart and bulk storage bins were cleaned at the time of identification. The pans that were identified were rewashed and allowed to air dry before storage. The refrigerators were cleaned at the time of identification. All produce will be inspected twice per day and documented on a log by the cook/designee. All refrigerated foods will be inspected for proper labeling and dating twice daily and documented on a log by the cook/designee. The hot plate cart and storage bins have been added to the cleaning schedule. The hot plate cart will be wiped down daily by the dietary aide/designee. The bulk storage bins will wiped down daily and thoroughly cleaned when emptied prior to refilling by the dietary aide/designee. The settings of the dish machine were changed to include heat sanitizing and a quick dry agent additive to the rinse cycle. The pans will be allowed time to air dry before storage by the dietary aide/designee. The walk-in refrigerators will be swept daily and mopped twice weekly by the dietary aide/designee. They will be deep cleaned monthly to include removing the shelving and thoroughly cleaning the floors. The cleaning schedule is clearly posted in the kitchen. The staff will sign off on the tasks as they are completed.	12/4/15

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F 371	Continued From page 22 was responsible for restocking the produce and removal of spoiled items to be returned to the vendor and when he was not available the utility person would take care of the produce. 2. During an observation on 11/2/15 at 9:25AM, the following items were unlabeled/undated opened whipped cream, 2 containers of fresh garlic, 1 package of tortilla wraps open, 2 packages of shredded cheese and 2 opened containers of chicken base/broth and 1/2 package of sugar cookies. During an interview on 11/2/15 at 9:25AM, the DM indicated that all foods opened should be labeled and dated once opened. 3. During an observation on 11/2/15 at 9:25AM, the hot plate cart had large volumes of dried food and grease build up on the inside and outside. During an interview on 11/2/15 at 9:25AM, the DM indicated that the kitchen staff was responsible for ensuring that all kitchen equipment was clean daily in accordance to the kitchen checklist. 4. During an observation on 11/2/15 at 9:25AM, the dry storage bins where the flour/sugar was contained had large volumes of dry foods/liquids on the inside and outside of the containers. During an interview on 11/2/15 at 9:25AM, the DM indicated that the kitchen staff was responsible for ensuring the storage bins were cleaned daily in accordance to the kitchen checklist. 5. During an observation on 11/2/15 at 9:25AM, there was 5 silver serving pans that were stacked wet on the dry storage shelves.	F 371	The dietary manager/designee will inspect the cleanliness of the kitchen weekly. The dietary manager/designee will conduct a food safety audit and a physical safety audit monthly and document the results. Results of the audits will be submitted to the QAPI committee monthly for review.	

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F 371	Continued From page 23 During an interview on 11/2/15 at 9:25AM, the DM indicated the kitchen staff was responsible for ensuring that the kitchen area was clean in accordance to the kitchen checklist. 6. During an observation on 11/2/15 at 9:25AM, the refrigerators had large amounts of dried meat blood on the flooring and trash on the shelves. During an interview on 11/2/15 at 9:25AM, the DM indicated that staff should clean the refrigerators weekly and ensure there was no dried liquids or trash left in the refrigerator. The DM presented a checklist for all the staff responsibilities in the kitchen. The checklist included cleaning schedules, labeling food items and discarding produce.	F 371		