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F 226 SS=B	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete criminal background checks for three (3) of three (3) nursing assistants before their dates of hire. The facility also failed to provide licensure verification for two (2) of two (2) licensed nurses before their dates of hire. The findings are: 1. A facility policy entitled Protection from Mistreatment, Neglect or Abuse, dated 11/17/10, read in part under screening: "The facility will obtain criminal background checks of all potential employees." Review of Nursing Assistant (NA) # 2's employee file revealed the date of hire was 08/18/11. Information within the file indicated NA#2 did not have a criminal background check result until 09/20/11. Review of NA #3's employee file revealed the date of hire was 04/21/11. Information within the file indicated NA #3 did not have a criminal background check result until 05/25/11. Review of NA #4's employee file revealed the date of hire was 07/14/11. Information within the	F 226		10/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/15/2011

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file indicated NA #4 did not have a criminal background check result until 08/10/11.

Review of Licensed Nurse (LN) #2's employee file revealed the date of hire was 06/21/11. Information within the file indicated LN #2 did not have a license verification result until 07/20/11.

Review of LN #3's employee file revealed the date of hire was 06/24/11. Information within the file indicated LN #3 did not have a license verification results until 07/27/11.

On 10/06/11 at 9:55 a.m. the Administrator was interviewed. She revealed the facility abuse policy required evidence that background checks were completed before newly hired nursing assistants went on the hall. The administrator said she did not have evidence to prove background checks were initiated before the newly hired nursing assistants went on the halls.

2. A facility policy entitled Protection from Mistreatment, Neglect or Abuse, dated 11/17/10, read in part under screening: "The facility will obtain information from licensure boards, registries or educational background training of potential employees.

Review of Licensed Nurse (LN) #2's employee file revealed the date of hire was 06/21/11. Information within the file indicated LN #2 did not have a license verification from the North Carolina Board of Nursing result until 07/20/11.

Review of LN #3's employee file revealed the date of hire was 06/24/11. Information within the file indicated LN #3 did not have a license verification from the North Carolina Board of

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F 226	Continued From page 2 Nursing results until 07/27/11 . On 10/06/11 at 9:50 a.m. The Director of Nursing (DON) was interviewed. She revealed she checks licensure during the interview process, however, she stated that for some reason she did not have anything in writing that she had checked the licenses for the above nurses. The DON provided license documents for Nurse # 2 and Nurse #3 which revealed no evidence when verification of their licenses had been initiated.	F 226		
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 observations, record review, and staff interviews, the facility failed to notify the kitchen of a diet change for one (1) of fourteen (14) sampled residents. (Resident #9) The findings are: Resident #9 was admitted to the facility with diagnoses including coronary artery disease, history of stroke, and high blood pressure. The latest Minimum Data Set (MDS) dated 08/11/11 indicated moderate impairment of cognition and memory. The MDS specified the resident is on a mechanically altered diet and requires limited staff assistance for all care. A review of Resident #9's medical record revealed a physician's order for a diet change	F 281		10/23/11

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dated 09/08/11. The order stated change diet to NAS (no added salt), mechanical soft, chopped meat, and regular liquids. The order was signed by Licensed Nurse (LN) #1 and indicated the order was noted 09/08/11.

An observation of the supper meal tray on 10/04/11 at 5:42 p.m. revealed a packet of salt was on the tray. The packet was observed unopened. An observation of the meal card on the resident's tray revealed no mention of NAS.

An observation of the lunch tray preparation in the kitchen on 10/05/11 at 12:08 p.m. revealed a salt packet was placed on Resident #9's lunch tray.

An observation of Resident #9's lunch tray in the resident's room on 10/05/11 at 12:45 p.m. revealed an opened and empty packet of salt. Seventy-five percent of the meal was eaten. An observation of the meal card on the resident's tray revealed no mention of NAS.

An interview with Nursing Assistant (NA) #1 on 10/05/11 at 12: 47 p.m. revealed if the salt packet was opened, it was used as requested by the resident. She stated it was normal practice if salt was on the lunch tray, the resident was asked if they want it.

An interview with the Director of Nursing (DON) and LN #1 on 10/05/11 at 2:02 p.m. revealed the usual practice for noting a new dietary order was to send a copy of the order on a diet slip to the kitchen. LN #1 stated the resident had returned to the facility on 09/08/11 from a cardiology consult. The physician had changed the diet order to reflect NAS. LN #1 stated she failed to fill out the diet slip to notify the kitchen. The DON

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F 281	Continued From page 4 stated it was her expectation for the nurses to follow facility protocol when noting physician orders.	F 281		
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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to inform staff or monitor physician recommendations for use of straws for two (2) of fourteen (14) sampled residents. The facility also failed to provide the correct food form for one (1) of fourteen (14) sampled residents. (Residents #12 and #6). The findings are: 1. Resident #12 was admitted to the facility with diagnoses including history of stroke and malnutrition. The latest Minimum Data Set (MDS) dated 08/17/11 indicated severe impairment of cognition and memory and dependence on staff assistance for all care. The MDS specified the resident required no assistance with eating after meal tray was setup by staff. A care plan dated 08/23/11 regarding malnutrition included an intervention for Speech Therapy referral for diet modification and	F 309		10/6/11

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strategies. An intervention dated 10/05/11 indicated "No Straws".

A review of Resident #12's medical record revealed a physician's order dated 09/27/11. The order specified the resident's diet was changed to mechanical soft with ground meats and no straws.

Further medical record review revealed a rehabilitation progress note written on a Interdisciplinary Team Meeting Report dated 09/27/11. The note specified the resident's diet was downgraded to mechanical soft, ground meat, and no straws related to a diagnosis of pneumonia.

a. An observation of the evening meal on 10/04/11 at 6:15 p.m. revealed a straw was placed in a drink cup. An observation of the resident's meal tray card revealed "No Straws" written on tray card. Further observation revealed no indication was in Resident #12's room to indicate no straws.

An observation of the lunch meal on 10/05/11 at 12:50 p.m. revealed a straw was present in the resident's water pitcher.

An interview was conducted with the Assistant Director of Nursing (ADON) and the Speech Therapist (ST) on 10/05/11 at 2:29 p.m. The ADON stated Resident #12 was followed by the Interdisciplinary Team and listed with other residents with specifications for no straws. The ST stated Resident #12 was presently receiving and being observed by speech therapy. She added "no straws" was recommended related to the resident's potential for aspiration resulting in

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pneumonia. The ADON and ST acknowledged the facility had not provided instruction to staff regarding not to use straws for Resident #12.

An interview with the Director of Nursing (DON) on 10/06/11 at 2:10 p.m. revealed the licensed nurse who noted the physician's order dated 09/27/11 was responsible to alert staff. The DON explained facility protocol was to place a sign on the wall over the head of a resident's bed to indicate "No Straws". The licensed nurse also had the responsibility of updating the nursing assistant's care plan. The DON acknowledged these things were not done. She continued she expected facility protocol was followed in order to inform staff of resident requirements.

b. An observation of the evening meal on 10/04/11 at 6:15 p.m. revealed Resident #12 received two (2) slices of ham. The resident was observed attempting to eat the sliced meat which had been cut into small bites. An observation of the meal tray card on the tray contained no indication of ground meat. Further observation at 6:30 p.m. revealed the facility provided the resident with ground ham.

An observation of the lunch meal tray preparation in the kitchen on 10/05/11 at 11:50 a.m. revealed Resident #12's meal tray card specified ground meat. Additional observation revealed a bulletin board facing the dietary aide placing the meal tray cards on the trays. The board contained various meal tray cards with recent dates. A card was observed dated 09/27/11 with Resident #12's name. The card specified ground meat.

An interview was conducted with the Speech Therapist (ST) on 10/05/11 at 2:29 p.m. The ST

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stated Resident #12 was presently receiving and being observed by speech therapy. She added the resident had a potential for aspiration resulting in pneumonia.

An interview via phone with Dietary Aide (DA) #1 on 10/05/11 at 4:06 p.m. revealed a dietary aide who worked the evening shift had called in ill on 10/04/11. DA #1 was asked to fill in. She stated when she arrived, the meal tray cards for the evening meal were set up by DA #2. The cards were ready for use. DA #1 stated she was unaware the cards were printed the week before and were out of date. DA #1 continued she used what was there and did not think about diets having the possibility of being changed.

An interview with DA #2 on 10/05/11 at 4:35 p.m. revealed she thought she would be required to work over due to the call in. She stated she had printed meal tray cards "last week". She was unable to recall the exact day. DA #2 stated she should have printed new meal tray cards for the evening meal on 10/04/11. She added she did not think about the possibly of diet changes.

An interview with the Dietary Manager (DM) on 10/05/11 at 12:15 p.m. revealed the meal tray cards for the evening meal on 10/04/11 were out of date. Continued interview with the DM on this date at 4:30 p.m. revealed the new diet orders are posted on a board positioned in front of dietary aide at the start of the meal tray preparation line. He stated the diet order dated 09/27/11 for Resident #12 should have been noted as a new order when the meal tray preparation was started. The DM stated usual dietary protocol required meal tray cards to be printed each day to ensure residents' diet orders

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were current. The DM added he expected dietary staff follow protocol.

2. Resident #6 was re-admitted to the facility with diagnoses including high blood pressure, possible stroke with seizures and difficulty swallowing.

The admission Minimum Data Set (MDS) dated 08/09/11 indicated impairment in short and long term memory and severe impairment in cognition for daily decision making. The resident required limited assistance from staff with eating after the meal tray was set up by staff.

A review of a physician's order dated 08/10/11 stated "no straws."

A review of a speech therapist progress note dated 08/16/11 indicated resident's diet was upgraded to a mechanical soft diet with ground meats and "no straws" due to the potential for aspiration.

On 10/06/11 at 1:40 p.m. a sign was observed attached to the wall over the resident's bed that stated "no straws." A water pitcher was observed sitting on the resident's overbed table with a straw in it.

During an interview on 10/06/11 at 1:50 p.m. with the speech therapist she stated Resident #6 had difficulty with swallowing. She stated she felt it was safer for the resident to avoid using straws to prevent the possibility of aspiration. The speech therapist verified there was a sign over the resident's bed that stated "no straws" and verified there was a water pitcher on the resident's overbed table with a straw in it.

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F 309	Continued From page 9 During an interview on 10/06/11 at 2:00 p.m. with the Assistant Director of Nurses (ADON) she stated resident #6 was on a list of residents that were not supposed to have straws and she should not have a water pitcher with a straw in it. She further stated that when there is a sign over a resident's bed stating "no straws" they should not have a straw in their water pitcher. During an interview on 10/06/11 at 2:05 p.m. with NA #5 she stated Resident #6 was not supposed to have a straw in her water pitcher. She verified the resident had a water pitcher on her overbed table with a straw in it. During an interview on 10/06/11 at 2:18 p.m. with the Director of Nurses (DON) she stated it was her expectation that a sign over a resident's bed stating "no straws" should alert staff that the resident was not supposed to have straws on their meal trays or in their water pitchers. She explained it was the responsibility of nursing to make sure staff were aware when residents were not supposed to have straws.	F 309		
F 323 SS=E	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	F 323		10/7/11

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by:
Based on observations and staff interviews the facility failed to monitor number of electrical receptacles utilized in three (3) of fifty-three (53) rooms, to prevent improper use of a household extension cord in one (1) of fifty-three (53) rooms, and to repair loose electrical receptacles in two (2) of fifty-three (53) rooms, or repair cracked electrical receptacles in five (5) of fifty-three (53) rooms. (Rooms #103, #111, #201, #205, #211, #301, #303, #306, #308, and #313).

The findings are:

1. Observations on 10/04/11 revealed electrical outlets in resident rooms were adapted to increase the number of available electrical receptacles.

a. An observation on 10/04/11 at 11:50 a.m. in Room #111 revealed a 4 receptacle red electrical outlet was located between resident beds. An oxygen concentrator which was in use was plugged into 1 receptacle. A feeding pump which was in use was plugged into 1 receptacle. An air mattress which was in use was plugged into 1 receptacle. The final receptacle contained a power strip with 4 additional receptacles. The power strip receptacles contained a plug for an oxygen concentrator, 2 nebulizer machines, and a suction machine. None of the devices plugged into the power strip were in use at the time of this observation.

b. An observation on 10/04/11 at 12:00 p.m. in Room #201 revealed a 2 plug adaptor containing a speaker and a radio plugged into one side of a duplex (2 receptacle) electrical outlet. A hi fi system was plugged into the other receptacle.

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c. An observation of 10/04/11 at 12:15 p.m. in Room #211 revealed a 2 plug adaptor containing a television and a cable box was plugged into one receptacle of a duplex electrical outlet.

An interview with the Maintenance Director on 10/04/11 at 3:27 p.m. revealed he checked resident rooms every 2 to 3 months to ensure electrical safety. He was unable to provide the date of his last inspection. The Maintenance Director stated the resident in Room #111 who required the majority of electrical devices had moved into that room 4 days ago. He stated he had not checked Room #111 since the move. The Maintenance Director explained the circuit breakers would trip when circuits were overloaded. He added he is not aware of any circuit breakers that have tripped and they have not had any fires or false alarms. The Maintenance Director stated plug extenders (adapters to increase the number of receptacles) are not permitted in the facility. He explained if he sees them in use, he removed them from resident rooms.

A tour of the facility with the Administrator and the Maintenance Director on 10/04/11 beginning at 4:00 p.m. verified the use of numerous electrical cords plugged into the 4 receptacle outlet in Room #111. The Administrator and Maintenance Director verified circuit breakers controlling this room had not tripped. The Administrator stated she saw a problem with the power strip utilized for medical equipment. She added the room and use of electrical equipment should have been monitored.

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2. An observation on 10/04/11 at 11:50 a.m. in Room #111 revealed a flat screen television and a satellite receiver plugged into the power strip. A refrigerator was also plugged into the power strip via use of a household extension cord. The power strip was plugged into a duplex (2 receptacle) electrical outlet

An interview with the Maintenance Director on 10/04/11 at 3:37 p.m. revealed household extension cords are not allowed in the facility. He added he checked rooms every 2 to 3 months to ensure extension cords were not used. The Maintenance Director was unable to provide the date of his last inspection. He continued when he sees household extension cords, he removed them from the facility.

A tour of the facility with the Administrator and Maintenance Director on 10/04/11 beginning at 4:00 p.m. verified the use of an extension cord in Room #111. The Maintenance Director stated he was not previously aware this extension cord was in use.

3. Observations on 10/04/11 revealed electrical receptacles in resident rooms were not securely holding plugs from devices.

a. Observations on 10/04/11 at 8:23 a.m. and 11:40 a.m. in Room #103 revealed the B bed was positioned against a wall. A lamp cord was plugged into an electrical outlet at the head of the bed. The resident was observed lying in the bed resting her head near the electrical outlet at 8:23 a.m. observation. The lamp cord was observed loosely plugged into the receptacle with prongs visible. The lamp was not in use at the time of

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these observations.

b. An observation on 10/04/11 at 12:03 p.m. in Room #301 revealed a 4 receptacle electrical outlet contained plugs from a nebulizer machine that was turned on, an air mattress that was turned on, an oxygen concentrator that was turned on, and a power supply that was lying on the floor. Each plug was hanging down with prongs visible.

An interview with the Maintenance Director on 10/04/11 at 3:27 p.m. revealed he checked resident rooms approximately every 2 to 3 months. His room checks included observing electrical outlets for needed repair. He was unable to provide the date of his last inspection. The Maintenance Director added the nursing staff who works out in the facility reported electrical outlets in need of repair. He explained work request forms were in a box by the time clock. As the nursing staff found broken equipment, they filled out a work request and left it in the box. The Maintenance Director stated he passed that box numerous times during the day and checked it each time. He had not received any requests for loose fitting plugs.

A tour of the facility was conducted with the Administrator and Maintenance Director on 10/04/11 beginning at 4:00 p.m. The Administrator and Maintenance Director verified the lamp in Room #103 was plugged into the electrical outlet and the prongs of the plug continued to be exposed. They also verified the loose plugs in Rooms #301. The Maintenance Director stated exposed prongs on a plugged in electrical cord could cause sparks. The Administrator acknowledged exposed prongs

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were a hazard potential.

4. Observations on 10/04/11 revealed electrical outlets in resident rooms with cracked receptacles.

a. An observation on 10/04/11 at 12:10 p.m. in Room #303 revealed a 4 receptacle electrical outlet contained 1 cracked receptacle exposing metal. This receptacle was not in use at the time of this observation.

b. An observation on 10/04/11 at 12:12 p.m. in Room #306 revealed a 4 receptacle electrical outlet contained 2 cracked receptacles. These receptacles were not in use at the time of this observation.

c. An observation on 10/04/11 at 12:16 p.m. in Room #308 revealed a 4 receptacle electrical outlet contained 1 cracked receptacle. This receptacle was not in use at the time of this observation.

d. An observation on 10/04/11 at 12:28 p.m. in Room #313 revealed a lamp sitting on a small table with an electrical cord plugged into the bottom receptacle of a duplex (2 receptacle) outlet. The top receptacle was observed covered in duct tape.

e. An observation on 10/04/11 at 3:05 p.m. in Room #205 revealed a 4 receptacle electrical outlet contained 1 cracked receptacle. No device was plugged into this receptacle at the time of this observation.

An interview with the Maintenance Director on

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F 323	Continued From page 15 10/04/11 at 3:27 p.m. revealed he checked resident rooms approximately every 2 to 3 months. He was unable to provide the date of his last inspection. One of the things he looks for is cracked electrical outlets. He added the nursing staff who works out in the facility reported outlets in need of repair as well. He explained work request forms were in a box by the time clock and as the nursing staff found broken equipment, they filled out a work request and left it in the box. The Maintenance Director stated he passed that box numerous times during the day and checked it each time. He had not received any requests for cracked receptacles except for Room #205 which he received about 20 minutes before this interview. A tour of the facility conducted with the Administrator and Maintenance Director on 10/04/11 beginning at 4:00 p.m. verified the outlets in Rooms #303, #306, #308, and #205 were cracked. In Room #313, the Maintenance Director removed the duct tape from the top receptacle of the duplex outlet and verified the receptacle was cracked. The Maintenance Director stated he was not aware of any of these cracked receptacles. An interview with the Administrator on 10/06/11 at 2:30 p.m. revealed all staff should be aware of safety issues throughout the facility. She added electrical safety was primarily the responsibility of the Maintenance Director. The Administrator stated she expected electrical issues to be addressed immediately and electrical safety to be maintained at all times.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		10/28/11

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The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews the facility staff failed to clean a glucometer before placing it inside a storage case that contained clean fingerstick blood sugar supplies in one (1) of two (2) residents observed. Resident # (12). Facility staff also failed to place a barrier for clean dressing supplies on a table during a dressing change for one (1) of one (1) resident observed. Resident # (4).

The findings are:

A review of a manufacturer's document titled "Quintet Blood Glucose Monitoring System" dated 2010 stated to use either an Environmental Protection Agency (EPA) registered disinfectant detergent or germicide that is labeled for use in a health care setting.

1. Resident # 12 was admitted to the facility with diagnoses including diabetes mellitus.

During an observation on 10/05/11 at 8:17 a.m. Licensed Nurse (LN) # 1 entered Resident # 12's room with a soft sided storage case in her hand. LN #1 washed her hands, put on gloves and took a lancet, a test strip and a glucometer (blood glucose meter) from the case and checked Resident #12's blood sugar. LN #1 placed the glucometer back inside the case with the clean lancets and test strips, removed her gloves, washed her hands and walked down the hallway to her medication cart. She locked the case inside the medication cart and started to give medications to other residents.

During an interview on 10/05/11 at 8:30 a.m. with

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LN #1 she explained nurses were supposed to use individually packaged disinfectant wipes which contained bleach and alcohol to clean the glucometers after a fingerstick blood sugar was done. She stated the facililty did not use glucometers for multiple residents but each resident who had a physician order for fingerstick blood sugars had a glucometer assigned to them. She further explained each resident's glucometer was stored in a soft sided storage case with lancets and test strips and the resident's name was on a label on the outside of the case. LN #1 verified she did not clean the glucometer after she did the fingerstick because she did not have any disinfectant wipes on her cart this morning and had to wait for a co-worker to bring them to her. She stated she cleaned the glucometer as soon as she received the wipes. She verified she placed the glucometer inside the soft sided storage case with the clean lancets and test strips after she checked Resident #12's blood sugar and stated she should have cleaned the glucometer before she put it in the case with the clean lancets and test strips.

During an interview on 10/05/11 at 4:15 p.m. with the Assistant Director of Nurses (ADON) she stated the facility provided a glucometer to each resident who had a physician order for fingerstick blood sugars. She further stated the glucometers were supposed to be cleaned after each use with individual pre-packaged disinfectant wipes.

During an interview on 10/05/11 at 4:30 p.m. with the Director of Nurses (DON) she stated she did not have a specific policy to clean glucometers but provided the "Quintet Blood Glucose Monitoring System" recommendations for cleaning to the nursing staff. She stated it was

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her expectation nursing staff should clean glucometers after each use with disinfectant wipes and nursing staff were responsible for keeping the disinfectant wipes supplied on their medication carts. She further stated nursing staff should not place glucometers inside the storage case before they were cleaned to avoid contamination of clean supplies.

2. Resident # 4 was admitted to the facility with diagnoses including Pressure Ulcer.

On 10/05/11 at 3:50 p.m., Licensed Nurese (LN) #4 was observed providing wound care to Resident #4. LN #4 washed her hands, gloved and removed the old dressing. Resident #4's coccyx area a tunneling Stage IV pressure ulcer was noted to have two areas of excoriation surrounding the pressure ulcer. LN #4 placed 4X4 gauze pads directly on the resident's wooden bedside table, poured normal saline onto the gauze pads and cleaned Resident #4's wound.

On 10/05/11 at 4:10 p.m., LN #4 was interviewed and acknowledged she placed the 4X4 gauze on the bed side table and poured normal saline onto the gauze. LN #4 further indicated she should have placed a barrier on the table prior to placing the gauze and pouring normal saline on the gauze.

An interview with the Director of Nursing (DON) on 10/06/11 at 12:50 p.m. revealed she would expect the nurse to clean the bed side table and place a barrier on the bed side table prior to placing wound care supplies.