STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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 309 SS=G	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 observation, record review, resident, and staff interviews the facility failed to assess pain levels during a dressing change for one (1) of three (3) sampled residents observed during skin care. (Resident #3). The findings are: Resident #3 was originally admitted to the facility on 12/29/10 with diagnoses of chronic obstructive pulmonary disease, high blood pressure and osteoporosis. The most recent quarterly Minimum Data Set dated 03/24/11 indicated no long or short term memory problems, and no impairment in cognition for daily decision making. The resident required extensive assistance by staff for personal care. The plan of care dated 12/29/10 indicated the resident had very fragile skin, was admitted with multiple skin tears, was at risk for poor healing of open areas and further skin impairment. The approaches listed on the plan of care indicated in part to use gentle touch when caring for resident to prevent skin tearing or bruising. On 01/31/11 the plan of care was updated to re-educate	F 309	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.** F 309 A. Resident # 3 was immediately assessed for pain and Tylenol is now given prior to each dressing change. The TAR is initialed by the Licensed Nurse to verify that pain has been assessed. B. Current patients with orders for dressing changes were audited to assure that pain was assessed prior to and during treatment. C. Licensed Nurses were re-educated on assessing and managing pain. DON/ Designee to QI monitor assessment of pain prior to and during dressing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ✓ Jane Jackson — TITLE: ✓ Administrator — (X6) DATE: ✓ 4-27-11

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 309	Continued From page 1 nurses and nurse aides regarding being careful during care due to extremely fragile skin. The physician orders dated 03/11/11 indicated Vicodin 5/500 one (1) orally every six (6) hours as needed for pain. The physician orders dated 03/17/11 stated check pain level prior to dressing change. The treatment record dated 04/01/11 - 04/30/11 stated check pain level prior to dressing change. On 04/05/11 at 1:53 p.m. LN #2 was observed entering Resident #3's room with dressing supplies. Resident #3 was sitting in a wheelchair next to her bed and LN #2 started to lift Resident #3's legs up onto the bed. Resident #3 grabbed the arms of her wheelchair and grimaced. LN #2 told Resident #3 to bend her legs and proceeded to lift her legs up onto the bed. LN #2 placed all of the dressing supplies on a clean towel on the overbed table and placed a plastic trash bag on the resident's bed. LN #2 washed her hands, put on gloves and began removing dressings on a large open wound on the inner side of Resident #3's right leg below her knee and two smaller skin tears on the back of her right leg. As LN #2 was removing the dressings Resident #3 was firmly grasping the arms of her wheelchair, held her head back, grimaced and said it hurt. LN #2 continued to remove the dressings, removed her gloves and washed her hands. She put on clean gloves and poured saline solution onto a sterile gauze dressing. LN #2 firmly pressed the saline gauze around and on top of the large wound, wiped firmly in a circular motion and repeated cleaning the wound in a circular motion three (3) times. During the cleaning, Resident #3 continued to firmly grasp the arms of her wheelchair and	F 309	changes for five residents 3 x weekly for four Weeks, one time weekly for four weeks and monthly thereafter for ten months. D. Results of QI monitoring will be reported to the RM/QI (Risk Management/ Quality Improvement) Committee monthly for 12 months. The Committee will assure compliance and make revisions to the plan as necessary. E. Completion Date 05/04/2011	

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F 309	Continued From page 2	F 309		

held her head back with a grimace on her face. LN #2 disposed of the soiled dressings into the trash bag on Resident #3's bed and removed her gloves. She applied a xeroform dressing to the wound, placed gauze dressings on top, wrapped kling wrap around the dressings and secured them with tape. LN #2 stated that the dressing was secure and Resident # 3 stated that it might be too tight. LN #2 patted the dressing with her hand, proceeded to put on gloves and clean the two skin tears on the back of Resident #3's leg using separate saline saturated gauze to firmly wipe around each wound in a circular motion. Resident #3 continued to grasp each arm of her wheelchair and hold her head back with a grimace on her face. LN #2 applied dressings to these wounds, removed her gloves and washed her hands. LN #2 put on clean gloves and removed the dressings on two small wounds on the shin of Resident #3's left leg. LN #2 changed her gloves and cleaned each wound with saline saturated gauze using firm circular pressure to each one while Resident #3 continued to firmly grasp each arm of her wheelchair and leaned her head back with a grimace on her face. LN #2 applied clean dressings to each wound, discarded the soiled dressings, removed her gloves and washed her hands. Resident #3 was then transported in her wheelchair to a resident group meeting.

On 04/05/11 at 2:28 p.m. an interview with LN #2 stated she usually talks to Resident #3 before the dressing changes but Resident #3 never complains of pain. LN #2 stated that she does not usually ask Resident #3 about her pain during a dressing change because Resident # 3 doesn't complain of pain. She explained the dressing changes are painful but the pain goes away when

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F 309	Continued From page 3 the dressing change is finished. LN #2 stated she cleaned the wounds with firm pressure to make sure that she got all of the old dressing material off of Resident #3's skin. LN #2 acknowledged Resident #3's skin is very fragile and she has had multiple skin tears and wounds on her legs. On 04/05/11 at 4:35 p.m. an interview with Resident #3 revealed staff don't ask her if she needs pain medication during the dressing changes. She stated it's very painful when they peel off the dressings and when they clean the wounds. She further stated she just bears the pain until the procedure is over and she would like for staff to have more conversation with her but they just do the dressing changes in silence. On 04/06/11 at 10:48 a.m. an interview with the director of nurses (DON) revealed it is her expectation for nurses to assess residents for pain before and during dressing changes and document it in nurses notes. The DON verified there was no documentation regarding pain assessment on the pain intervention flowsheet or nurses notes for the dressing change on 04/05/11.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.**	

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F 329	Continued From page 4 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to check resident's allergies before administering a medication for one (1) of fifteen (15) sampled residents. (Resident #14) The findings include: Resident #14 was readmitted to the facility on 12/18/2010 with diagnoses including Urinary Tract Infection (UTI). A hospital discharge summary for Resident #14 dated 12/17/10 documented discharge diagnosis of Klebsiella urinary tract infection on gentamicin intravenously. The hospital discharge summary further documented urinalysis on admission showed evidence of infection. The hospital discharge summary documented Resident #14 has multiple drug allergies and the only medication that she can take for which she is not	F 329	F 329 A. Resident # 14 was discharged from the facility after completion of her Rehab. LN#3 was re-educated individually regarding receiving physician's orders for drugs B. Current residents' drug regimens were audited to assure that they were receiving no drugs that were clinically contraindicated C. Licensed Nurses were re-educated on checking allergy list prior to administrating medications and receiving new physicians orders. DON/Designee will QI monitor 5 residents 3x weekly for three weeks, one time weekly for 4 weeks and monthly for ten months D. The results of the QI monitoring will be reported to the RM/QI Committee monthly for 12 months. The	

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F 329	Continued From page 5 allergic to was gentamicin intravenously. The hospital discharge summary documented infectious disease consultant was obtained and they recommended gentamicin IV for ten days. A hospital medication administration record (MAR) dated 12/17/10 included Cipro as one of multiple medication allergies for Resident #14. Review of Resident # 14's facility face sheet included Ciprofloxacin (Cipro) as one of multiple medication allergies. The facility face sheet did not list the type of reaction Resident # 14 had to Cipro. A lab urine culture dated 12/22/10 for Resident #14, documented Escherichia coli (E. coli) isolated. A hand written note on the lab result dated 12/28/10 at 11:30 AM documented results called to nurse practitioner (NP) repeat urinalysis and culture and sensitivity in one week. A physician's order dated 01/05/11 for Resident #14, documented urinalysis with culture and sensitive. The lab urine culture dated 01/06/11 for Resident #14, documented Escherichia coli (E. coli) isolated. A physician's order dated 01/11/11 for Resident # 14, documented a verbal order from the nurse practitioner to the licensed nurse (LN) #3 for Cipro 500 milligrams (mg) twice a day for seven days. A nurse note for Resident #14 dated 1/11/11 at 6:00 PM, documented resident #14 in no acute distress. Resident #14 continues on antibiotics for UTI, no side effects noted. A nurse note for Resident #14 dated 1/12/11 at 11:00 PM documented she was receiving antibiotics for UTI.	F 329	Committee will assure compliance and make revisions to the plan as needed. E. Completion date 5/4/2011	

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F 329	Continued From page 6	F 329		

A physician's order dated 01/17/11 at 2:00 PM for Resident #14, documented order from the nurse practitioner (NP) to the licensed nurse to discontinue Cipro and give gentamicin 70 mg intramuscularly every 8 hours for 3 days.

The facility medication administration record (MAR) for Resident #14 documented she received Cipro 500 mg by mouth, twice a day on 1/11/11 at 9:00 AM and 8:00 PM, on 1/13/11 at 9:00 AM and 8:00 PM, on 1/14/11 at 9:00 AM and 8:00 PM, on 1/15/11 at 9:00 AM and 8:00 PM,on 1/16/11 at 9:00 AM and on 1/17/11 at 9:00 AM.

Review of Resident #14's January 2011 MAR revealed Cipro was not listed as a medication allergy.

During an interview with the Medical Director on 04/06/11 at 3:00 PM, he revealed medication selection depended on the culture and sensitivity test. He would expect the pharmacy to catch medication allergy that a resident may have. He revealed the licensed nurse will give the resident's allergies when calling for a medication order.

During an interview with the Director of Nursing (DON) on 04/06/11 at 4:58 PM she revealed the facility received Resident #14 allergies from the hospital MAR. She stated residents' allergies are listed on the hospital discharge summary and hospital medication reconciliation sheet. She revealed on admission, the licensed nurse will write the allergies on the MAR and fax the MAR and hospital discharge summary to the pharmacy. She also revealed an allergy stickers was placed on the chart. She revealed when a licensed nurse

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F 329	Continued From page 7 called the physician or nurse practitioner for a medication order, the licensed nurse should give pertinent information such as labs, allergies, test results, vital signs to them. She further revealed checking allergies against medications is a team approach that includes the physician, nurse practitioner, and the licensed nurse. She revealed for a new medication the nurse administering the first dose should look at the MAR, allergy sticker and face sheet for allergies. She revealed licensed nurses should check the MAR for allergies prior to administering the medication. She revealed licensed nurse (LN) #3 received the physician order for Cipro. During an interview with LN #3 on 04/06/11 at 5:13 PM, she revealed she did receive the physician order for Resident # 14 to receive Cipro. LN #3 could not recall if she did or not did not give the nurse practitioner Resident # 14's allergies. During an telephone interview with LN #4 on 04/06/11 at 5:38 PM, she revealed she recalled Resident # 14 receiving Cipro. LN #4 revealed the MAR did not have Cipro listed as an allergy for Resident #14. She further revealed stated that Resident #14 did not have any side effects from receiving the Cipro.	F 329		
F 371 SS=F	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	F 371	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.**	

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

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to 1) maintain the final rinse temperature of the dish machine consistently at 180 degrees 2) ensure dishware in clean storage was thoroughly cleaned prior to storage and 3) ensure a knife stored ready for use in the kitchen was in good repair. The findings are: 1. During the initial tour of the facility kitchen on 4/9/11 from 1:10 PM-2:15 PM and 2:25 PM-2:30 PM observations were made of the final rinse temperature of the dishmachine as it was in use by dietary staff. The manufacturer label on the dish machine indicated the final rinse temperature should reach a minimum of 180 degrees Fahrenheit (F). The first two observations of the dish machine the final rinse temperature reached 185 and 180 degrees F. Continued observations of the final rinse temperature of the dish machine revealed the highest temperatures to be: 1:30 PM 174 degrees F. This rack of dishes was run through the dish machine a second time after the Food Service Director (FSD) saw the final rinse temperature. 1:32 PM 176 degrees F. The rack of dishes was pulled out and stored in clean storage. 1:35 PM 172 degrees F. The rack of dishes was pulled out and rewashed a second time. 1:38 PM 178 degrees F. The rack of dishes was pulled out and stored in clean storage. 1:40 PM 175 degrees F. The rack of dishes was	F 371	F 371 A. Upon being notified, the Dietary Manager immediately stopped the use of the Dish machine and contacted the Contract Company to repair the machine. An element on the booster heater was replaced. Prior to replacement of the element the Dietary Manager observed machine temperatures and allowed intervals between rinses to assure temperatures reached 180 degrees. At no time after CDM was notified were rinse temperatures below 180 degrees. Bowls with debris were rewashed and inspected to insure cleanliness. Broken knife was discarded. B. A sanitation audit was conducted to ensure proper final rinse temperatures of the dish machine are consistently maintained, All dishware in clean storage is thoroughly cleaned prior to storage, and all untensils ready for use in the kitchen are in good repair.	

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F 371	Continued From page 9 pulled out and stored in clean storage. At the time of the observation the FSD stated the company that services the dish machine had been in the building last week and the service technician had no concerns with the final rinse temperature. The FSD asked if there was a concern with the final rinse temperature and the aide washing the dishes at the dish machine reported the final rinse temperature was 175 degrees F. 1:42 PM 174 degrees F. The rack of dishes was pulled out and stored in clean storage. After viewing the final rinse temperature gauge the FSD left the vicinity of the dish machine. 1:45 PM 170 degrees F. The rack of dishes was pulled out and stored in clean storage. 1:46 PM 171 degrees F. The rack of dishes was pulled out and stored in clean storage. 1:47 PM 168 degrees F. The rack of dishes was pulled out and stored in clean storage. 1:48 PM 172 degrees F. The rack of dishes was pulled out and stored in clean storage. A second dietary aide came to assist with washing dishes. 1:50 PM 172 degrees F. The rack of dishes was pulled out and stored in clean storage. 1:52 PM 170 degrees F. The rack of dishes was pulled out and stored in clean storage. After viewing the final rinse temperature gauge the FSD left the vicinity of the dish machine. 1:55 PM 174 degrees F. The rack of dishes was pulled out and stored in clean storage. After this observation the FSD was asked about any concerns with the final rinse temperature of the dish machine. The FSD stated she had called the contract company to come in and check the dish machine. 1:56 PM 172 degrees F. The rack of dishes was pulled out and stored in clean storage. After viewing the final rinse temperature gauge the	F 371	C Dietary staff were reeducated on sanitation and checking equipment temperatures, as well as proper procedures for malfunctioning equipment Dietary Manager /designee will randomly QI monitor Dish MachineTemperatures and general dish sanitation five times weekly for two weeks,3 times weekly for 2 weeks, then once weekly for four weeks, then monthly for 10 months. . D. Results of QI monitoring will be reported to the RM/QI Committee monthly for 12 months. The Committee will assure compliance and make revisions to the plan as needed. E. Completion date 5/04/2011	

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F 371	Continued From page 10 FSD was asked about the facility procedure if there were concerns with the final rinse temperature of the dish machine. The FSD stated the contract company was called and they come out as soon as possible. 1:58 PM 170 degrees F. The rack of dishes was pulled out and stored in clean storage. 1:59 PM 170 degrees F. The rack of dishes was pulled out and stored in clean storage. The FSD returned to the dish machine area and told the aides to stop using the dish machine for ten minutes and then restart the machine and check the final rinse temperature. During the ten minute wait the FSD was asked again about the facility practice when the final rinse temperature did not reach 180 degrees F. The FSD stated the three compartment sink would be utilized until the final rinse temperature reached 180 degrees F. The FSD was asked at what point the three compartment sink would be utilized and the FSD reported, now. 2:10 PM 184 degrees F. 2:11 PM 179 degrees F. The dietary aide stated, we need to give it a break between washing dishes. At 2:15 PM the surveyor exited the kitchen. 2:25 PM 166 degrees F. The dishes were taken to the three compartment sink by the dietary aide. At 3:35 PM the contract company that services the dish machine reported the pressure setting was adjusted to address the problem with the final rinse temperature. On 4/5/11 at 10:00 AM the final rinse temperature of the dish machine was 176 degrees F. The FSD was present during the observation and reported the contract company was going to come back to the facility to repair the dish	F 371		

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F 371	Continued From page 11 machine. The FSD asked the aide doing dishes to wait five minutes between running the dish machine to see if the final rinse temperature would get to 180 degrees F. At 10:10 AM the final rinse temperature of the dish machine was 180 degrees F. On 4/6/11 at 1:20 PM the FSD stated the element of the booster heater in the dish machine had been replaced and the final rinse temperatures were now consistently reaching 180 degrees F. 2. On 4/5/11 at 10:15 AM two bowls stored in clean storage were noted to have a significant amount of food debris covering the interior portion of the bowl. The FSD was present during the observation and reported the food debris appeared to be vegetable soup. The FSD stated the bowls should have been inspected by staff washing dishes prior to storing in clean storage. 3. On 4/5/11/ at 10:15 AM a large knife was stored in a knife block ready for use. The tip of the knife was broken and the broken end was slightly bent. The FSD was present at the time of the observation and reported she was not aware the tip of the knife was broken. The FSD stated broken knives should be discarded and replaced.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.**	

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	345473	A. BUILDING _____ B. WING _____	04/06/2011

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F 431	Continued From page 12 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to discard expired medication on two (2) of three (3) medication carts and failed to store three opened, undated insulin vials on two (2) of three (3) medication carts. The findings are: 1. Observation of the 100 hall medication cart on 04/04/11 at 1:40 PM, revealed one (1) opened	F 431	F 431 A. Undated Insulin, charcoal Plus and Prostat on the 100 hall cart were immediately removed and discarded. Undated insulin and expired Tylenol on 400 Hall cart were immediately discarded B. Medication carts and medication rooms were audited by the Omni Care Pharmacy QA Consultant for expired or undated medications and medications were discarded as neccessary C. Licensed Nurses were reeducated on appropriate dating of medications and discarding of expired medications. DON/Designee will Random QI monitor medication rooms and medication carts five times weekly for four weeks, weekly for four weeks and monthly for ten months. D. Results of QI monitoring will be reported to the RM/QI Committee monthly for 12 months. The Committee will assure compliance and make	

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F 431	Continued From page 13 Lantus 100 units/ml insulin vial without a opened/discard date, one (1) Novolin Regular 100 units/ml insulin vial opened without a opened/discard date, one bottle of Charoal Plus 36 count tablets with an expiration date of February 2011, and Prostat 64–887 milliliters (ml) bottle opened with an expiration date of February 2011. During an interview with a licensed nurse (LN) #1 on 04/04/11 at 1:50 PM. She confirmed the insulin was opened and not dated. She revealed when insulin is opened and put on the cart, the insulin vial should be labeled with an opened/discard date. 2. Observations of the 400 hall medication cart on 04/04/11 at 2:00PM revealed one (1) opened Lantus 100 units/ml insulin vial without a opened/discard date and Tylenol 16 fluid ounce (fl oz) bottle opened with expiration date of March 2011. During an interview with a licensed nurse (LN) #2 on 04/04/11 at 2:00PM. She confirmed the insulin was opened and not dated and the Tylenol was expired. She revealed the licensed nurse who opens the insulin vial should label with an opened/discard date. She revealed that the night shift nurse should check the cart for expired medications. During an interview with the Director of Nursing (DON) on 04/05/11 at 10:34 AM, she revealed third shift nurses and the pharmacist should be checking for unlabeled and expired medications monthly. She revealed no residents were receiving Charcoal or Prostat. She revealed the licensed nurses were required to date the insulin	F 431	revisions to the plan as needed E. Completion date 5/04/2011	

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F 431	Continued From page 14 vials when opened for use.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the physician and mental health practitioner the facility failed to ensure staff documented oxygen saturation percentages on a resident receiving continuous oxygen by nasal cannula for one (1) of four (4) sampled residents reviewed for oxygen administration. The facility also failed to document a penicillin allergy on the physician's orders and medication administration record for one (1) of fifteen (15) sampled residents and failed to ensure mental health service drug reviews of two (2) of six (6) sampled residents were accurate. (Residents #1, #3, #4) The findings are: 1. (a) Resident #3 was originally admitted on 12/29/10 with diagnoses of chronic obstructive	F 514	**this Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.** F 514 A. Oxygen saturation percentage documentation was immediately began on resident #3. Resident# 3 's allergy was immediately written on the Physician's order sheet and MAR. A new Nurse Practitioner from the Contract Mental Health Group was assigned to review resident #4 and resident #1. B. An audit was conducted to assess properly documented oxygen saturation on residents receiving continuous oxygen, current residents allergy lists were audited to assure allergies were listed on MAR,	

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

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F 514	Continued From page 15 pulmonary disease, high blood pressure and osteoporosis. The physician orders dated 01/25/11 through 04/30/11 indicated resident was to receive oxygen at two (2) liters per minute via nasal cannula to keep oxygen saturation percentages greater than ninety (90) percent. The medication administration record dated 04/01/11 through 04/06/11 indicated an oxygen saturation percent of ninety-five (95) percent was documented on first shift on 04/01/11. There were no oxygen saturation percentages documented for second and third shift on 04/01/11, no oxygen saturation percentages documented for any of the three shifts from 04/02/11 through 04/05/11 and no oxygen saturation percentage documented for first shift on 04/06/11. On 04/06/11 at 10:13 a.m. an interview with the director of nurses (DON) verified nursing staff documented their initials on the medication administration record instead of recording the actual oxygen saturation percentages for second and third shift on 04/01/11, on all shifts from 04/02/11 through 04/05/11 and on first shift on 04/06/11. On 04/06/11 at 3:02 p.m. the physician was interviewed. He stated he expected nursing staff to check the resident's oxygen saturation percentage daily for each shift and the oxygen saturation percentage should be documented for each shift. (b) Further review of the medical record of Resident # 3 revealed a discrepancy in	F 514	B. resident's face sheet, front cover of chart and physician's order sheet. Residents receiving Mental Health Services were assigned a new NP by the Contract Mental Health Group. Mental Health Service Drug reviews were audited for residents receiving care by the DON to assure drug review matched current medication orders C. Licensed nursing staff were re-education on oxygen saturation percentage documentation and verifying accuracy of allergy list The DON /Designee will randomly QI monitor O2 saturation documentation, and allergy list accuracy, three times weekly for 3 weeks, weekly 4 weeks. Then monthly for ten months. DON/Designee will audit Mental Health Service Drug review monthly to assure it matches current medication orders. D. Results of QI monitoring will be reported to the RM/QI Committee monthly for 12	

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F 514	Continued From page 16 documentation of Resident # 3's allergies. A sticker located inside the front cover of Resident #3's medical record stated Allergic: Penicillin. A review of the face sheet indicated allergies: Penicillin. A review of the physician's orders and the Medication Administration Record (MAR)indicated Resident #3 had no known allergies. On 04/06/11 at 10:32 a.m. an interview with the director of nurses (DON) revealed she was unaware the sticker and face sheet indicated the resident had an allergy to Penicillin but the physician order sheet and medication administration records indicated no known allergies. She stated the nurse should have written penicillin on the initial physician order sheet when the resident was re-admitted on 01/25/11 in order for the pharmacy to include the allergy on the printed physician order sheet and the medication administration record. On 04/06/11 at 10:46 a.m. the DON confirmed the pharmacy had the resident listed in their database as having no known allergies. 2. Resident #4 was originally admitted to the facility 10/1/09 and readmitted 6/14/10 with diagnoses that included dementia without behaviors and depression. Review of physician orders revealed the resident's current medications included an antidepressant, Celexa 20 mg every day. Review of consult progress notes in the resident's medical record included services from a contract mental health group. The initial request for the services noted mental health treatments included	F 514	months. The Committee will assure compliance and and make revisions to the plan as needed E Completion date 5/4/2011	

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F 514	Continued From page 17 an assessment and pharmacological management. The mental health Nurse Practitioner (NP) assessed Resident #4 on 11/4/10 and 2/17/11. The Evaluation and Management (Psychiatry) progress notes included a review of "Current Psychotropic Meds with Dosage" to assist with "Medical Decision Making" and "Recommendations/Orders (Med Changes, Labs & Refills". The "Current Psychotropic Meds with Dosage" on the 11/4/10 and 2/17/11 notes indicated Resident #4 was taking .25 Klonopin every 12 hours as needed, 10 milligrams of Aricept and 20 milligrams of Celexa. Review of the medical record of Resident #4 noted the Klonopin had been discontinued 3/22/10 and the Aricept was discontinued on readmission 6/14/10. On 4/6/11 at 11:25 AM the mental health NP was interviewed by telephone. The mental health NP stated her role was to review any concerns as well as make recommendations for medication management to the resident's medical physician. The mental health NP stated she includes psychotropic medications and generates the medication list from her prior assessment. The mental health NP stated she did not update the medication listing for Resident #4 when her evaluations were done 11/4/10 and 2/17/11. On 4/6/11 at 3:30 PM the resident's medical physician stated the NP with mental health services was supposed to review residents medications and make recommendations. The resident's physician stated he reviewed the recommendations and made changes if indicated. 2. Resident #1 was admitted to the facility	F 514		

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F 514	Continued From page 18 4/20/09 and readmitted 2/19/11 with diagnoses that included dementia and depression. Review of physician orders revealed the resident's current medications included .5 milligrams of Risperdal (an antipsychotic) twice a day and 10 milligrams of Celexa (an antidepressant) every day. Review of consult progress notes in the resident's medical record included services from a contract mental health group. The initial request for the services noted mental health treatments included an assessment and pharmacological management. The mental health Nurse Practitioner (NP) assessed Resident #1 on 3/3/11. The Evaluation and Management (Psychiatry) progress notes included a review of "Current Psychotropic Meds with Dosage" to assist with "Medical Decision Making" and "Recommendations/Orders (Med Changes, Labs & Refills". The "Current Psychotropic Meds with Dosage" on the 3/3/11 notes indicated Resident #1 was taking 10 milligrams of Aricept (a dug to treat dementia) every day and .5 milligrams of Ativan (an anti anxiety medication) as needed every day. Review of the medical record of Resident #1 from 3/2010-current did not reveal a time the resident was taking either the Aricept or Ativan. On 4/6/11 at 11:25 AM the mental health NP was interviewed by telephone. The mental health NP stated her role was to review any concerns as well as make recommendations for medication management to the resident's medical physician. The mental health NP stated she includes psychotropic medications and generates the medication list from her prior assessment. The mental health NP stated she did not update the	F 514		

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F 514	Continued From page 19 medication listing for Resident #1 when her evaluation was done on 3/3/11. On 4/6/11 at 3:30 PM the resident's medical physician stated the NP with mental health services was supposed to review residents medications and make recommendations. The resident's physician stated he reviewed the recommendations and made changes if indicated.	F 514		