STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING _____ B. WING _____	C 04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility failed to provide dignity during morning care for 1 of 4 sampled residents dependent on staff for activities of daily living. (Resident 26) The findings are: Resident #26 was admitted to the facility on 5/5/10. Diagnoses included cerebrovascular accident, chronic obstructive pulmonary disease, ataxia, depression, anxiety, and cataracts. A quarterly minimum data set (MDS) dated 4/8/11 assessed Resident #26 as having moderately impaired cognition and requiring extensive staff assistance with personal hygiene and bathing. The facility's policy "Resident's Right to Privacy During Care", undated, recorded in part, "It is the policy of this facility to provide privacy for resident's when performing resident care activities. 1. When performing personal care for a resident, the staff will ensure that privacy is secured prior to beginning the care. 2. If the resident is in their room the staff member will ensure. a. The door to the room is closed. b. The privacy curtain is pulled around the resident's side of the room; c. If the resident is next to the	F 241	**ALEXANDRIA PLACE'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.** • F241: **ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** ALEXANDRIA PLACE PROMOTES CARE FOR RESIDENTS IN A MANNER AND IN AN ENVIRONMENT THAT MAINTAINS OR ENHANCES EACH RESIDENT'S DIGNITY AND RESPECT IN FULL RECOGNITION OF HIS OR HER INDIVIDUALITY. THERE WAS NO HARM TO THE ONE MENTIONED RESIDENT. THE FACILITY HAS AN APPROPRIATE POLICY AND THE EXPECTATION OF THE POLICY TO BE FOLLOWED AT ALL TIMES. THERE WAS ONE C.N.A NOTED AS BEING INVOLVED. THE C.N.A WAS COUNSELED WITH ON 4/28/11 BY THE STAFF DEVELOPMENT COORDINATOR REGARDING RESIDENT DIGNITY AND PRIVACY. **ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** NINE OTHER RESIDENTS IN THE CARE OF THE 1 C.N.A HAD THE POTENTIAL TO BE AFFECTED. THE C.N.A WAS COUNSELED ON 4/28/11 BY THE STAFF DEVELOPMENT COORDINATOR.	5/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly L. Faulk	Administrator	5-22-11

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.

CMS FORM
MAY 24 2011
BY: _____

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F 241	Continued From page 1 window and the blinds are open they will be closed; and if raised they will be lowered to completely obstruct view from the outside." On 4/26/11 at 9:30 AM, the room door for Resident #26 was open, the privacy curtain was pulled partially around the bed, leaving the foot of the Resident's bed exposed with her legs and the lower portion of her brief exposed. Resident #26's bed was next to the window. The blinds were open and lowered such that the lower half of the window was exposed to the outside. The window faced the courtyard. Resident #26 was instructed to sit up on the edge of her bed by Nursing Assistant #5 (NA #5).When Resident #26 sat up on edge of bed; she was not wearing any clothing, exposing her breasts. The blinds were still open, lowered approximately half way and the Resident's door remained open. An interview with NA #5 on 4/26/11 at 9:45 AM confirmed that she had been trained on providing dignity while giving care. NA #5 stated that she received an in-service approximately six months prior regarding providing dignity during resident care. NA #5 stated she did not realize that the blinds were not pulled all the way down while she provided morning care to Resident #26. She stated "When they mow, someone could see in, I should have pulled the blinds down." She provided no explanation as to why the Resident's door was not closed or why the resident was not covered during care. In an interview on 4/26/11 at 9:50 AM, Resident #26 stated that she would prefer the blinds closed, "They should close the blinds, I am shy and I don't want everyone to see me."	F 241	THE STAFF DEVELOPMENT COORDINATOR GAVE INSERVICES FOR ALL FACILITY STAFF REGARDING PRIVACY AND DIGNITY ON MAY 5, 2011. THE FACILITY'S POLICY WAS ALSO REVIEWED WITH STAFF ON MAY 5, 2011 DURING THE INSERVICE. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: THE STAFF DEVELOPMENT COORDINATOR GAVE INSERVICES FOR ALL FACILITY STAFF REGARDING PRIVACY AND DIGNITY ON MAY 5, 2011. THE FACILITY'S POLICY WAS ALSO REVIEWED WITH STAFF ON MAY 5, 2011 DURING THE INSERVICE. INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: THE NURSE MANAGER WILL COMPLETE A WEEKLY GENERAL UNIT CHECK LIST- QUALITY ASSURANCE CHECKLIST WHICH INCLUDES CHECKING TO ENSURE THAT DOORS ARE CLOSED COMPLETELY, BLINDS ARE CLOSED COMPLETELY FOR RESIDENTS IN "B" BEDS AND THAT PRIVACY CURTAINS ARE PULLED AROUND THE RESIDENT WHILE CARE IS PROVIDED. THE NURSE MANAGER IS TO IMMEDIATELY INTERVENE AND CORRECT SITUATIONS AS THEY ARISE.	

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F 241	Continued From page 2 The staff development coordinator (SDC) was interviewed on 4/28/11 at 10:40 AM and stated that staff were trained to provide privacy with care by closing the door and the blinds and pulling the privacy curtain. The SDC further stated that NA #5 last received an in-service on 3/11/10 regarding "Kindness and Sensitivity" which included a discussion on giving privacy with care to include closing doors, blinds and pulling the privacy curtain. An interview with the director of nursing (DON) on 4/28/11 at 11:45 AM revealed that she expected the privacy and dignity of a resident to be protected during care. The DON stated that that the door should be closed, privacy curtain pulled around the bed and the blinds closed during resident care. The DON further stated that if a visitor enters a resident's room, the resident's privacy should be protected such that nothing is visible on the resident.	F 241	THE GENERAL UNIT CHECKLIST- Q.A. CHECKLIST WILL BE TURNED IN TO THE DIRECTOR OF NURSING, WEEKLY FOR INITIAL REVIEW AND THEN WILL BE TURNED INTO THE Q.A. COMMITTEE ON AT LEAST A QUARTERLY BASIS FOR REVIEW AND DETERMINATION IF FURTHER OR AMENDED ACTION IS REQUIRED. THE Q.A. COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the cleanliness of a mechanical lift utilized for resident transfers. The findings are:	F 253	• F253: ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: THE FACILITY PROVIDES HOUSEKEEPING AND MAINTENANCE SERVICES NECESSARY TO MAINTAIN A SANITARY, ORDERLY AND COMFORTABLE INTERIOR. PER THE CITATION, TWO RESIDENTS WERE NOTED, HOWEVER DID NOT HAVE ANY HARM. THE MECHANICAL LIFT WAS IMMEDIATELY CLEANED ON 4/26/11. ON 4/26/11 THE DIRECTOR OF NURSING REVISED THE NIGHT SHIFT CLEANING ASSIGNMENT TO INCLUDE THE MECHANICAL LIFTS.	5/26/11

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F 253	Continued From page 3 On 04/26/11 at 3:19 p.m., Nursing Assistants (NAs) #1 and #2 were observed transferring Resident #16 from bed to chair utilizing a mechanical lift. The lift was observed with dust on all flat surfaces and a brown colored smear on the left side of the bar that holds the sling. At 3:30 p.m. the same two NAs were observed transferring Resident # 10 from bed to chair utilizing the same mechanical lift. At 3:46 p.m. NAs #3 and #4 were observed transferring Resident #67 from bed to chair utilizing the same mechanical lift. Resident #67 was observed using her hand to hold onto the right side of the bar holding the sling. The mechanical lift was unchanged in appearance throughout all these transfers. An interview with NA #1 immediately after the 3:19 p.m. transfer revealed she did not know who cleaned the mechanical lift. An interview with NA #3 on 04/26/11 at 3:54 p.m. revealed she did not know who cleaned the mechanical lift. An interview with the Assistant Director of Nursing (ADON) on 04/26/11 at 4:19 p.m. stated the third shift is responsible for cleaning any equipment utilized for residents. At this time, she observed the mechanical lift and acknowledged the lift needed to be cleaned. An interview with the Director of Nursing (DON) on 04/27/11 at 11:38 a.m. revealed the third shift had a list of equipment for which they were responsible to clean. She added the mechanical lift was left off their cleaning list. The DON stated she expected the mechanical lift to be kept clean	F 253	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: SIXTEEN OUT OF SIXTY RESIDENTS USE THE TOTAL MECHANICAL LIFT AND HAD THE POTENTIAL TO BE AFFECTED. NONE OF THE RESIDENTS WERE HARMED. THE MECHANICAL LIFT WAS IMMEDIATELY CLEANED ON 4/26/11. ON 4/26/11 THE DIRECTOR OF NURSING REVISED THE NIGHT SHIFT CLEANING ASSIGNMENT TO INCLUDE THE MECHANICAL LIFTS. THE NIGHT SHIFT NURSE IS TO SIGN THE CLEANING ASSIGNMENT SHEET TO VERIFY COMPLETION. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: ON 4/26/11 THE DIRECTOR OF NURSING REVISED THE NIGHT SHIFT CLEANING ASSIGNMENT TO INCLUDE THE MECHANICAL LIFTS. THE NIGHT SHIFT NURSE IS TO SIGN THE CLEANING ASSIGNMENT SHEET TO VERIFY COMPLETION. THE NURSE MANAGER WILL COMPLETE A WEEKLY GENERAL UNIT CHECK LIST- QUALITY ASSURANCE CHECKLIST WHICH INCLUDES CHECKING TO ENSURE THAT THE MECHANICAL LIFTS ARE CLEAN. THE NURSE MANAGER IS TO IMMEDIATELY INTERVENE AND HAVE UNCLEAN LIFTS, CLEANED.	

INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.:

THE NURSE MANAGER WILL COMPLETE A WEEKLY GENERAL UNIT CHECK LIST- QUALITY ASSURANCE CHECKLIST WHICH INCLUDES CHECKING TO ENSURE THAT THE MECHANICAL LIFTS ARE CLEAN. THE NURSE MANAGER IS TO IMMEDIATELY INTERVENE AND HAVE UNCLEAN LIFTS, CLEANED.

THE GENERAL UNIT CHECKLIST- Q.A. CHECKLIST WILL BE TURNED IN TO THE DIRECTOR OF NURSING, WEEKLY FOR INITIAL REVIEW AND THEN WILL BE TURNED IN TO THE Q.A. COMMITTEE ON AT LEAST A QUARTERLY BASIS FOR REVIEW AND DETERMINATION IF FURTHER OR AMENDED ACTION IS REQUIRED.

THE Q.A. COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED.

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F 253	Continued From page 4 for resident use.	F 253		
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 medical record review and interviews the facility failed to obtain laboratory tests ordered by the Physician for one (1) of ten (10) residents reviewed for unnecessary medication use. (Resident #20) The facility also failed to clarify physician orders for one (1) of one (1) sampled residents reviewed for Preadmission Screening and Resident Review and one (1) of one (1) sampled residents with physician orders for nasal spray. (Residents #21 and #9). The findings are: 1. Resident #20 was admitted on 08/18/08 with diagnoses including Vascular Dementia with Delusions, Depressive Disorder, and Generalized Anxiety Disorder with behavioral disturbances. The quarterly Minimum Data Set (MDS) dated 03/30/11 indicated Resident #20 had moderately impaired cognition and was able to make her needs known. The quarterly MDS noted Resident #20 received antipsychotic, antidepressant, and hypnotic medications during the last seven (7) days. Review of Physician's orders for April 2011 revealed Resident #20 had current Physician's orders for and received antipsychotic (Abilify) and	F 281	F281: ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ALEXANDRIA PLACE PROVIDES SERVICES THAT MEET PROFESSIONAL STANDARDS OF QUALITY. THE RECOMMENDATIONS WERE MADE BY THE PSYCHOLOGICAL SERVICE PROVIDER THAT IS CONTRACTED WITH THE FACILITY. ONE RESIDENT WAS NOTED AS BEING AFFECTED. THE ITEMS IDENTIFIED WERE CORRECTED ON 4/28/11. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: SEVEN OUT OF SIXTY RESIDENTS RECEIVE CONTRACTED NURSE PRACTIONER PSYCHOLIGICAL SERVICES AND HAD THE POTENTIAL TO BE AFFECTED. THEIR CHARTS WERE REVIEWED BY THE ASSISTANT DIRECTOR OF NURSING TO ENSURE THAT ORDERS WERE CLARIFIED WITH THE ATTENDING PHYSICIAN OR NURSE PRACTIONER AND THE ORDERS THAT THE ATTENDING PHYSICIAN OR NURSE PRACTIONER WANTED TO PROCEED WITH WERE TRANSCRIBED AND FOLLOWED. NO OTHER RESIDENT WAS IDENTIFIED AS BEING AFFECTED. NO RESIDENT WAS HARMED.	5/26/11

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F 281	Continued From page 5 mood stabilizing (Valproic Acid) medications on a daily basis. Further review of Physician's orders revealed Resident #20 had received the antipsychotic medication since 03/16/10 and the mood stabilizer since 04/06/10. Continued review of the medical record revealed Resident #20 received psychological health services with clinician recommendations noted as follows: - 01/07/11- HgA1c (measures average daily blood glucose over several months) on next laboratory day and every six (6) months due to antipsychotic use. Valproic acid level every six (6) months. The Nurse Practitioner (NP) accepted and signed the recommendations on 01/14/11. - 02/25/11- The clinician documented in the progress note she would await results of the HgA1c and Valproic acid level recommended at the last visit. The NP accepted and signed the recommendations on 03/02/11. - 03/10/11- HbA1c and Valproic acid level on next laboratory day. The NP accepted and signed the recommendations on 03/15/11. - 04/15/11- Valproic acid level next laboratory day. The NP accepted and signed the recommendations on 04/19/11. Review of Resident #20's laboratory test results revealed a Valproic acid level was last checked in 06/2010. Further review of laboratory tests results from 06/2010 through 04/25/11 revealed no results for HgA1c. During an interview on 04/27/11 at 4:00 PM Licensed Nurse (LN) #1 stated her usual practice was to place psychological health services	F 281	**ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** ON MAY 2, 2011 A NEW SYSTEM WAS PUT IN PLACE TO ENSURE THAT PARADIGM RECOMMENDATIONS ARE FOLLOWED UP ON APPROPRIATELY. ON MAY 2, 2011, THE DIRECTOR OF NURSING COMMUNICATED THIS SYSTEM CHANGE TO THE ASSISTANT DIRECTOR OF NURSING, 3-11 NURSE MANAGER AND MEDICAL RECORDS NURSE. ON MAY 3, 2011 THE MEDICAL DIRECTOR RECEIVED, REVIEWED AND SIGNED A COPY OF THE NEW SYSTEM. THE RECOMMENDATIONS WILL BE GIVEN TO THE ATTENDING PHYSICIAN OR EVERCARE NURSE PRACTIONER TO REVIEW. AFTER THE M.D. OR N.P. HAS REVIEWED THE RECOMMENDATIONS AND MADE THEIR DECISION TO ACCEPT OR DECLINE, THE RECOMMENDATIONS WILL BE FORWARDED TO THE ASSISTANT DIRECTOR OF NURSING. THE ASSISTANT DIRECTOR OF NURSING WILL MAKE A NOTATION, SIGN AND DATE THE PARADIGM MEDICATION MANAGEMENT PROGRESS NOTE TO SIGNIFY THAT THE RECOMMENDATIONS WERE REVIEWED AND APPROPRIATELY ADDRESSED.	

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F 281	Continued From page 6 progress notes in the Physician's folder for review. LN #1 further explained after the Physician/NP accepted and signed off on the recommendation(s) she could transcribe the orders to the residents medical record. An interview with the Medical Records Director (MRD) on 04/27/11 at 4:47 PM revealed she gave psychological health services progress notes to the attending Physician/NP for review while making weekly rounds. The MRD further stated once the Physician/NP completed the review and signed any recommendations she gave the progress note to the residents' assigned nurse to be processed. An interview was conducted with the Director of Nursing (DON) on 04/27/11 at 5:00 PM. During the interview the DON stated, once the Physician/NP accepted and signed off on psychological health services recommendations, she expected licensed nursing staff to transcribe the recommendation(s) as an order and ensure laboratory tests were completed. During an interview on 04/28/11 at 8:30 AM the NP reviewed the progress notes for Resident #20's psychological health services dated 01/07/11, 02/25/11, 03/10/11, and 04/15/11 and confirmed she had accepted and signed off on the recommendations noted by the clinician. The NP further stated once she accepted and signed off on the recommendations she expected licensed nursing staff would transcribe the recommendations as Physician's orders and ensure laboratory tests were completed.	F 281	INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: A NEW SYSTEM WAS PUT IN PLACE TO ENSURE THAT PARADIGM RECOMMENDATIONS ARE FOLLOWED UP ON APPROPRIATELY. THE RECOMMENDATIONS WILL BE GIVEN TO THE ATTENDING PHYSICIAN OR EVERCARE NURSE PRACTIONER TO REVIEW. AFTER THE M.D. OR N.P. HAS REVIEWED THE RECOMMENDATIONS AND MADE THEIR DECISION TO ACCEPT OR DECLINE, THE RECOMMENDATIONS WILL BE FORWARDED TO THE ASSISTANT DIRECTOR OF NURSING. THE ASSISTANT DIRECTOR OF NURSING WILL MAKE A NOTATION, SIGN AND DATE THE PARADIGM MEDICATION MANAGEMENT PROGRESS NOTE TO SIGNIFY THAT THE RECOMMENDATIONS WERE REVIEWED AND APPROPRIATELY ADDRESSED.	

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F 281	Continued From page 7 2. Resident #21 was readmitted to the facility 11/15/10 and 01/14/11 with diagnoses including Metabolic Encephalopathy and Dementia. A review of Resident #21's medical record revealed medical consults occurred 01/27/11 and 03/24/11. A review of the consultant's progress notes for each date listed Remeron 15 milligrams (mg) at bedtime as a medication recommendation. On the 01/27/11 report, the facility Attending Physician signed the report at the bottom of the page. On the 03/24/11 report, a check mark by "Accept" was observed with the Attending Physician's signature dated 04/14/11. Continued review of Resident #21's medical record revealed Remeron 15 mg at bedtime was ordered by the Attending Physician on 09/17/10. Resident #21 was discharged to an acute care facility on 11/10/11 and returned to the long term care facility on 11/15/10. A review of the acute care discharge summary dated 11/15/10 did not list Remeron as a medication to be continued in long term care. Resident #21 was discharged a second time on 01/04/11 to an acute care facility and returned to the long term facility 01/14/11. A review of the acute care discharge summary	F 281	ON A MONTHLY BASIS FOR THREE MONTHS, THE DIRECTOR OF NURSING WILL REVIEW THE PARADIGM PROGRESS NOTES AFTER THE ASSISTANT DIRECTOR OF NURSING HAS ADDRESSED THE RECOMMENDATIONS TO ENSURE THE SYSTEM IS BEING FOLLOWED AND IS WORKING. IF THE DIRECTOR OF NURSING DETERMINES SYSTEM CHANGES NEED TO BE MADE, THE DIRECTOR OF NURSING WILL BRING THIS BEFORE THE Q.A. COMMITTEE FOR REVIEW. THE DIRECTOR OF NURSING WILL REPORT HER FINDINGS REGARDING HER FOLLOW UP DURING THE QUARTERLY Q.A. COMMITTEE MEETING.	

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F 281	Continued From page 8 dated 01/14/11 did not list Remeron as a medication to be continued in long term care. Further review of monthly Physician orders for the months of 12/10, 1/11, 2/11, 3/11, and 4/11 revealed no order for administration of Remeron. An interview with the Medical Records Director (MRD) on 04/27/11 at 4:47 p.m. revealed she gives the written medical consultant progress notes to the Attending Physician to be reviewed and signed. When the Attending Physician has completed his review, the MRD gives the progress notes to the individual nurses attending each resident to process recommendations. An interview with the Director of Nurses (DON) on 04/27/11 at 5:00 p.m. revealed she expected the nurses to clarify recommendations of medical consultants with the Attending Physician. The DON acknowledged this was not done. 3. Resident #9 was readmitted to the facility 03/17/2011. Review of the medical record revealed a 04/19/2011 Physician's Telephone Order that read "Fluticasone (corticosteroid to decrease inflammation) Nasal Spray (symbol for 2) bid (twice daily) X (times) 3 days then qd (every day) X (times) 14 days." On Resident #9's April 2011 Medication Administration Record (MAR) the 04/19/2011 physician's order read "Fluticasone nasal spray (symbol for 2) sprays BID (twice daily) X 3 days each nare then: one spray each nare qd (every day)." Review of administration directions on the pharmacy	F 281		

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	345441	A. BUILDING _____ B. WING _____	C 04/28/2011

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F 281	Continued From page 9 dispensing label revealed Resident #9 was to be administered Fluticasone Nasal Spray "2 (two) sprays in each nostril" throughout the course of the medication. On 04/27/11 at 10:05 AM an interview was completed with Licensed Nurse (LN) #3, assigned to Resident #9. During the interview LN #3 reviewed the 04/19/2011 Physician's Telephone Order and the pharmacy dispensing label for Resident #9's Fluticasone Nasal Spray and stated the directions included administration of two (2) sprays to each nostril for the duration of the order. LN #3 reviewed the April 2011 MAR for Resident #9 and confirmed that the 04/19/2011 physician's order as transcribed included directions to administer two sprays Fluticasone Nasal Spray in each nostril for three (3) days followed by one (1) spray per nare for the remaining fourteen (14) days. LN #3 stated Resident #9's April 2011 MAR did not accurately reflect the 04/19/2011 physician's order for Fluticasone Nasal Spray. The interview further revealed no clarification order was available regarding the physician's 04/19/2011 order for Resident #9's nasal spray. On 04/28/2011 at 1:55 PM an interview was completed with the Assistant Director of Nursing (ADON). During the interview the ADON reviewed the 04/19/2011 Physician's Telephone Order for Resident #9's Fluticasone Nasal Spray and stated that the order, as written, was unclear and did not indicate whether two sprays were to be administered in each nostril or if a total of two sprays were to be administered, one spray per nare. The ADON reviewed the April 2011 MAR for Resident #9 and stated the MAR did not	F 281		

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F 281	Continued From page 10 accurately reflect the 04/19/2011 physician's order. The ADON stated the physician's order should have been clarified prior to administration of the medication. Interview, 04/28/2011 at 2:30 PM, with the Director of Nursing (DON) revealed Resident #9's 04/19/2011 Physician's Telephone Order for Fluticasone Nasal Spray should have been clarified.	F 281		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility failed to provide a half cup serving of bread according to the menu for 2 of 2 sampled residents. (Residents #63 and #7) The findings are: 1. On 4/27/11 at 11:12 AM, during a kitchen observation, the following pureed foods were available for the lunch meal service: beef macaroni casserole, broccoli and peaches. Additionally, a four ounce cup containing approximately two ounces of bread crumbs was included on the lunch tray for residents on a pureed diet. The menu recorded residents on a	F 363	• F363: ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ALEXANDRIA PLACE DOES HAVE MENUS THAT MEET THE NUTRITIONAL NEEDS OF RESIDENTS IN ACCORDANCE WITH THE RECOMMENDED DIETARY ALLOWANCES OF THE FOOD AND NUTRITION BOARD OF THE NATIONAL RESEARCH COUNCIL, NATIONAL ACADEMY OF SCIENCES; AND ARE PREPARED IN ADVANCED AND ARE FOLLOWED. NO RESIDENT WAS FOUND TO HAVE ANY ADVERSE AFFECTS OR HARM. BREAD CRUMBS WILL NO LONGER BE SERVED IN INDIVIDUAL CUPS. THE BREAD WILL BE PUREED IN WITH THE RESIDENT'S MEAT.	5/26/11

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F 363	Continued From page 11 pureed diet were to receive a half cup of pureed bread or four ounces of bread crumbs. Review of the label for bread crumbs revealed that a half cup serving would provide 220 calories, 2 grams of fat and 8 grams of protein. Dietary Staff #1 was interviewed on 4/27/11 at 11:55 AM and stated that residents who received a pureed consistency diet received the same foods which were prepared for residents on a regular consistency diet. These foods were pureed, but dietary staff usually did not add a thickener to the pureed consistency foods, but rather a container of bread crumbs was placed on the residents' meal tray for nursing staff to add the bread crumbs to residents' food to thicken as needed. An interview with the dietary manager (CDM) on 4/27/11 at 12:07 PM revealed that she expected nursing staff to use their judgment when adding bread crumbs to the food of resident's on a pureed consistency diet. She further stated that she did not realize residents on a pureed diet were to receive a half cup of bread crumbs with their meal. The CDM instructed dietary staff to fill the four ounce cup about half (two ounces) full of bread crumbs and put it on the meal tray for residents on a pureed diet for nursing staff to add as needed. She confirmed that a total of 14 residents received a pureed consistency diet with about two ounces of bread crumbs offered in a cup for nursing staff to add to their foods. On 4/27/11 at 12:30 PM Resident #63 was observed with a double portion of a pureed consistency lunch meal in the main dining room. Resident #63 received pureed beef macaroni	F 363	**ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** APPROXIMATELY FOURTEEN RESIDENTS ARE ON A PUREED DIET AND HAD THE POTENTIAL TO BE AFFECTED. NO RESIDENT WAS AFFECTED OR HARMED. BREAD CRUMBS WILL NO LONGER BE SERVED IN INDIVIDUAL CUPS. THE BREAD WILL BE PUREED IN WITH THE RESIDENT'S MEAT. ON MAY 10, 2011 THE CERTIFIED DIETARY MANAGER INSERVICED THE DIETARY STAFF REGARDING THIS CORRECTIVE ACTION. **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** ON MAY 19, 2011 THE CERTIFIED DIETARY MANAGER AND THE LICENSED NURSING HOME ADMINISTRATOR ATTENDED A PRESENTATION BY THE COALITION FOR CULTURE CHANGE REGARDING AN IMPROVED METHOD FOR PREPARING PUREED FOODS. BREAD CRUMBS WILL NO LONGER BE SERVED IN INDIVIDUAL CUPS. THE BREAD WILL BE PUREED IN WITH THE RESIDENT'S MEAT. ON MAY 10, 2011 THE CERTIFIED DIETARY MANAGER INSERVICED THE DIETARY STAFF REGARDING THIS CORRECTIVE ACTION.	

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F 363	Continued From page 12 casserole, pureed broccoli, pureed peaches and approximately two ounces of bread crumbs. The bread crumbs were not added by staff to the pureed consistency foods received by Resident #63. On 4/27/11 at 2:45 PM, an interview with the consultant dietician (RD) revealed that she had monitored test trays for the facility, but not for resident's on a pureed diet. The RD stated that she was not aware that bread crumbs were on the meal tray for a resident on a pureed consistency diet for nursing staff to use to thicken pureed foods. On 4/28/11 at 8:52 AM nursing assistant #5 (NA #5) stated that she often fed Resident #63 her meals. NA #5 stated that she "hardly ever" added the bread crumbs to this Resident's food because Resident #63 did not like the bread crumbs. NA #5 further stated that bread crumbs were not always available on the meal tray for Resident #63. On 4/28/11 at 8:59 AM, Dietary Staff #2 confirmed that she filled a four ounce cup "about half full", as instructed, with bread crumbs for residents on a pureed consistency diet. On 4/28/11 at 3:30 PM, during a follow-up interview with the CDM and the RD, the CDM stated that Resident #63 often refused the bread crumbs. The CDM also stated that since the Resident's family often came to feed her lunch, the dietary manager could not say if an alternate bread was offered to Resident #63 at lunch. The RD stated that the portions, as recorded on the menu, were what staff tried to follow.	F 363	INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: THREE TIMES A WEEK FOR THREE MONTHS THE CERTIFIED DIETARY MANAGER WILL OBSERVE THE COOK PUREE MEAT WITH BREAD FOR ONE MEAL TO ENSURE THE APPROPRIATE AMOUNT OF BREAD AND MEAT ARE BEING USED. THE CERTIFIED DIETARY MANAGER WILL MAKE IMMEDIATE CORRECTIONS SHOULD THE NEED ARISE. AFTER THREE MONTHS, THE CERTIFIED DIETARY MANAGER WILL OBSERVE THE MEAT AND BREAD BEING PUREED ONCE MONTHLY TO ENSURE THE CORRECTION HAS BEEN SUSTAINED. THE RESULTS OF THE Q.A. OBSERVATIONS WILL BE REPORTED TO THE Q.A. COMMITTEE AT LEAST ON A QUARTERLY BASIS FOR REVIEW AND DETERMINATION IF FURTHER OR AMENDED ACTION IS REQUIRED. THE Q.A. COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED.	

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F 363	Continued From page 13 2. On 4/27/11 at 11:12 AM, during a kitchen observation, the following pureed foods were available for the lunch meal service: beef macaroni casserole, broccoli and peaches. Additionally, a four ounce cup containing approximately two ounces of bread crumbs was included on the lunch tray for residents on a pureed diet. The menu recorded residents on a pureed diet were to receive a half cup of pureed bread or four ounces of bread crumbs. Review of the label for bread crumbs revealed that a half cup serving would provide 220 calories, 2 grams of fat and 8 grams of protein. Dietary Staff #1 was interviewed on 4/27/11 at 11:55 AM and stated that residents who received a pureed consistency diet received the same foods which were prepared for residents on a regular consistency diet. These foods were pureed, but dietary staff usually did not add a thickener to the pureed consistency foods, but rather a container of bread crumbs was placed on the residents' meal tray for nursing staff to add the bread crumbs to residents' food to thicken as needed. An interview with the dietary manager (CDM) on 4/27/11 at 12:07 PM revealed that she expected nursing staff to use their judgment when adding bread crumbs to the food of resident's on a pureed consistency diet. She further stated that she did not realize residents on a pureed diet were to receive a half cup of bread crumbs with their meal. The CDM instructed dietary staff to fill the four ounce cup about half (two ounces) full of bread crumbs and put it on the meal tray for	F 363		

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F 363	Continued From page 14	F 363		

residents on a pureed diet for nursing staff to add as needed. She confirmed that a total of 14 residents received a pureed consistency diet with about two ounces of bread crumbs offered in a cup for nursing staff to add to their foods.

Resident #7 was observed on 4/27/11, in the main dining room, at 12:35 PM eating a double portion pureed consistency lunch meal. Resident #7 received pureed beef casserole, pureed broccoli, and pureed peaches. A bread portion was not available to Resident #7 on his lunch meal tray. Resident #7 was fed by Nursing Assistant #6 (NA #6) who stated that Resident #7 usually did not receive bread crumbs added to his food. NA #6 also stated that Resident #7 did not always receive bread with his meal.

On 4/27/11 at 2:45 PM, an interview with the consultant dietician (RD) revealed that she had monitored test trays for the facility, but not for residents on a pureed diet. The RD stated that she was not aware that bread crumbs were on the meal tray for a resident on a pureed consistency diet for nursing staff to use to thicken pureed foods.

On 4/28/11 at 8:59 AM, dietary staff #2 confirmed that she filled a four ounce cup "about half full", as instructed, with bread crumbs for residents on a pureed consistency diet.

On 4/28/11 at 3:30 PM, during a follow-up interview with the CDM and the RD, the CDM stated that Resident #7 often refused the bread crumbs and did not always receive bread crumbs on his meal tray. The CDM could not confirm that an alternate bread had always been offered to

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F 363	Continued From page 15 Resident #7. The RD stated that the portions, as recorded on the menu, were what staff tried to follow.	F 363		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility failed to complete hand hygiene between tasks during the tray line meal service. The findings are: The facility's policy "Hand Washing Procedures", undated, included in part, "To prevent transmission of bacteria, hands are to be frequently and thoroughly washed. Hands must be washed: (3) After touching your hair or skin." A lunch meal tray line observation occurred on 4/27/11 at 11:12 AM. The alternate menu included pork chops. Dietary staff #1 was observed wearing gloves. Dietary staff #1 was observed to scratch the back section of her head using her gloved right hand at 11:20 AM. The	F 371	• F371: ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ALEXANDRIA PLACE PROCURES FOOD FROM SOURCES APPROVED OR CONSIDERED SATISFACTORY BY FEDERAL, STATE OR LOCAL AUTHORITIES. ALEXANDRIA PLACE DOES STORE, PREPARE, DISTRIBUTE, AND SERVE FOOD UNDER SANITARY CONDITIONS. THE KITCHEN IS EVALUATED BY THE HEALTH DEPARTMENT ON A QUARTERLY BASIS. THE FACILITY'S KITCHEN HAS MAINTAINED AN "A" RATING. THE CERTIFIED DIETARY MANAGER PROVIDES FREQUENT INSERVICE EDUCATION TO THE DIETARY STAFF. THE CITED DIETARY EMPLOYEE HAD BEEN INSERVICED REGARDING HANDWASHING ON 2/9/11. THE CERTIFIED DIETARY MANAGER IMMEDIATELY DISCARDED THE NOTED TRAY AND THE COOK IMMEDIATELY RE-WASHED HER HANDS. NO RESIDENT WAS HARMED OR FOUND TO HAVE BEEN AFFECTED.	5/26/11

ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

THE RESIDENTS WHO HAD THEIR MEALS PREPARED BY THIS COOK PRIOR TO WASHING HER HANDS COULD HAVE BEEN POTENTIALLY AFFECTED, HOWEVER; THIS WAS PREVENTED AT TIME OF SURVEY AS A NEW TRAY WAS PREPARED AND THE COOK RE-WASHED HER HANDS.

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

THE CERTIFIED DIETARY MANAGER INSERVICED THE DIETARY STAFF REGARDING HAND HYGIENGE ON MAY 4, 2011.

INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.:

THE CERTIFIED DIETARY MANAGER IS TO MONITOR AT LEAST TEN TRAYS , THREE TIMES A WEEK USING THE DIETARY DEPT. TRAY CARD Q.A. ROUND FORM. DURING THIS Q.A. OBSERVATION, THE CERTIFIED DIETARY MANANGER IS TO OBSERVE DIETARY STAFF ON THE TRAY LINE TO ENSURE PROPER HAND HYGIENE IS BEING FOLLOWED. IF THE CERTIFIED DIETARY MANAGER OBSERVES IMPROPER HAND HYGIENE, THE CERTIFIED DIETARY MANAGER IS TO TAKE IMMEDIATE ACTION AT THE TIME OF THE ROUND TO MAINTAIN SANITARY CONDITIONS.

THE RESULTS OF THIS WEEKLY Q.A. WILL BE REPORTED TO THE Q.A. COMMITTEE QUARTERLY FOR REVIEW AND DETERMINATION IF FURTHER OR AMENDED ACTION IS REQUIRED.

THE Q.A. COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED.

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F 371	Continued From page 16 lunch meal tray line began at 11:21 AM. At 11:30 AM, dietary staff #1 used her gloved right hand to break apart a pork chop, plated the pork chop and the resident's meal tray was placed on the cart for delivery. The cart was ready to exit the kitchen at 11:33 AM. The Dietary Manager confirmed in an interview at 11:34 AM that staff should wash hands and change gloves before touching resident's food if gloves have become soiled or contaminated. Dietary staff #1 stated at 11:35 AM that she received training about one month prior regarding hand washing. She confirmed that she knew to wash her hands and to change gloves if her gloves became soiled or contaminated. Dietary staff #1 stated she did not realize that she scratched her head with her gloved hand. Review of a roster for an in-service "Proper hand washing" provided on 2/9/11 documented instruction, in part, "Wash hands after touching body parts, like nose, hair, scratching arms or eyes, etc." Dietary staff #1 signed the in-service.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441	• F441: ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ALEXANDRIA PLACE HAS ESTABLISHED AND MAINTAINED 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. ONE ROOM WAS CITED AS AFFECTED. NO RESIDENT WAS HARMED OR AFFECTED.	5/26/11

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F 441	Continued From page 17 (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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to change mop water and mop head after mopping a room designated as Standard Precautions. The findings are: An undated facility policy stated if a resident's room is designated as Standard Precautions additional steps need to be followed which included after mopping the room, the mop water and mop should be changed and not used again	F 441	ON 4/27/11 THE ADMINISTRATOR INSERVICED THE HOUSEKEEPERS REGARDING THE FACILITY'S EXPECTATION AND POLICY REGARDING WHEN MOP WATER AND MOP HEADS ARE TO BE CHANGED. THE HOUSEKEEPERS WERE TOLD TO CHANGE THEIR MOP WATER AFTER EVERY THIRD ROOM. IF THERE WERE ANY ROOMS DESIGNATED FOR STANDARD PRECAUTATIONS, MOP WATER AND MOP HEADS WERE TO BE CHANGED AFTER MOPPING SUCH ROOMS. **ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** ON 4/27/11 THE ADMINISTRATOR INSERVICED THE HOUSEKEEPERS REGARDING THE FACILITY'S EXPECTATION AND POLICY REGARDING WHEN MOP WATER AND MOP HEADS ARE TO BE CHANGED. THE HOUSEKEEPERS WERE TOLD TO CHANGE THEIR MOP WATER AFTER EVERY THIRD ROOM. IF THERE WERE ANY ROOMS DESIGNATED FOR STANDARD PRECAUTATIONS, MOP WATER AND MOP HEADS WERE TO BE CHANGED AFTER MOPPING SUCH ROOMS. **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** THE FACILITY WAS IN THE PROCESS OF CHANGING THE MOPPING SYSTEM PRIOR TO THE SURVEY PROCESS. THE FACILITY WILL CONTINUE IMPLEMENTING THIS CHANGE WHICH WILL CONSIST OF A MICROFIBER MOPPING SYSTEM.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING _____ B. WING _____	C 04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(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 441	Continued From page 18 until the mop has been sanitized. An observation on 04/27/11 at 9:46 a.m. revealed Housekeeper #1 cleaning a room designated Standard Precautions. The Housekeeper was observed mopping the floor as the last cleaning task. She placed the mop back in the water bucket on the housekeeping cart and moved to the next room. Housekeeper #1 was observed mopping the floor in the next room using the same mop head and mop water as utilized in the room designated Standard Precautions. In an interview with Housekeeper #1 on 04/27/11 at 10:04 a.m., she stated it was her intention to change the mop water after cleaning one more room. She stated after mopping a room designated Standard Precautions, she would not change the water if the floor did not appear really dirty. An interview with the Administrator on 04/27/11 at 11:38 a.m. revealed she expected mop head and mop water to be changed after mopping a room designated Standard Precautions.	F 441	THE HOUSEKEEPERS WILL CHANGE MOP HEADS AFTER EACH ROOM. THE WATER BUCKET WILL BE ELIMINATED AS THE MICROFIBER MOP HEADS WILL BE PRE-SOAKED IN THE CLEANING SOLUTION. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: THE HOUSEKEEPERS WILL CHANGE MOP HEADS AFTER EACH ROOM. THE WATER BUCKET WILL BE ELIMINATED AS THE MICROFIBER MOP HEADS WILL BE PRE-SOAKED IN THE CLEANING SOLUTION. WHILE THE CHANGE IS IN PROCESS, THE HOUSEKEEPING SUPERVISOR WILL MAKE A WEEKLY Q.A.ROUND TO ENSURE THAT THE HOUSEKEEPERS ARE FOLLOWING THE NEW MICROFIBER MOPPING SYSTEM. AFTER THE SYSTEM HAS BEEN IN PLACE FOR A MONTH, THE HOUSEKEEPING SUPERVISOR WILL MAKE A MONTHLY Q.A. ROUND TO OBSERVE A HOUSEKEEPER MOPPING A THREE ROOM STRETCH AT MINIMUM TO INCLUDE A STANDARD PRECAUTIONS ROOM, IF THERE IS ONE. THE HOUSEKEEPING SUPERVISOR IS TO IMMEDIATELY INTERVENE AS NEEDED TO ENSURE THIS PORTION OF THE INFECTION CONTROL PROGRAM IS NOT COMPROMISED.	

THE HOUSEKEEPING SUPERVISOR IS TO TURN IN HER Q.A. OBSERVATIONS TO THE Q.A. COMMITTEE ON A QUARTERLY BASIS FOR REVIEW AND DETERMINATION IF FURTHER OR AMENDED ACTION IS REQUIRED.

THE Q.A. COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED.