STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 05/19/2011

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BRIAN CTR HEALTH & REHAB/GASTO	969 COX RD GASTONIA, NC 28054

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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 observations, resident and staff interviews, and medical record reviews, the facility failed to 1) provide timely incontinence care (Resident #1), 2) respect residents' decisions related to care (Resident #5 and #25), and 3) await invitation from the resident prior to entering the room (resident council group) for three (3) of twenty-four (24) sampled residents and six (6) of fourteen (14) residents in the resident council group. The findings are: 1. Resident #1 was readmitted with diagnoses including hemiplegia, type 2 diabetes, and below-the-knee amputation. The most recent Minimum Data Set (MDS) dated 3/21/11 revealed intact cognition and dependence on staff assistance for activities of daily living, including toilet use and personal hygiene. The MDS revealed frequent incontinence of bowel but no behavioral symptoms or rejection of care. During an interview on 5/17/11 at 5:05 p.m., Resident #1 reported he would be more comfortable at the facility if the call light response was quicker. The resident stated, "Honey, I've waited here over an hour for somebody to come.	F 241	This Plan of Correction is the facility's credible allegation of compliance. 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 1 by ensuring residents call light is being answered in a timely manner and his needs are met. Resident #5 receives medications according to physician order and in a manner that maintains dignity during administration. Corrective action has been accomplished for residents by ensuring all staff knock on resident room doors prior to entering to ensure dignity and privacy is provided. Corrective action has been accomplished for resident # 25 by ensuring medication is administered as written by physician and staff identifying themselves when entering the room to provide services. 2. Residents with the potential to be affected by the same alleged deficient practice have been identified through audit of current residents for incontinence care needs, medication administration by mouth and residents who can Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6-21-11

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.

APPROVED
JUN 22 2011
BY: MH

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F 241	Continued From page 1 I've lain in my own waste and finally got up and went to the 100 hall to get pads, wash cloths, and things because this cart [pointing toward a linen cart in the hall] was empty." Resident #1 stated he was sure of the time because he checked the clock in his room. The resident said he wasn't sure of the exact date but said it happened the week before on the 3-11 shift. He reported a Nursing Assistant (NA) answered his call light "two or three times" but did not attempt to assist him. The resident stated each time she answered the call light, she told him she would tell [NA #5] and left the room. The resident said he did not know the name of this NA. Resident #1 stated he was "frustrated and angry" that he was left to lie in his own waste for such a long time. An interview with NA #4 on 5/19/11 at 5:15 p.m. revealed the resident told her about the incident but she did not know who the NA involved was. NA #4 stated the resident told her he was told by another NA that NA #5 would come to help him. During an interview on 5/19/11 at 5:30 p.m., NA #5 revealed she had assisted Resident #1 during the evening shift in question. She stated she was assigned the other end of the hall but had just walked out of one of her residents' rooms, saw his call light was on and she answered it. The NA said no one had reported to her Resident #1 had requested help. She stated, "I didn't know he was in that situation" and said she saw the soiled linens piled on his bed. NA#5 stated the resident told her he had repeatedly rung the call bell and finally went to get his own supplies from another cart because the cart on his hall was out. She stated she cleaned him up and reported the incident to the nurse on duty at the time. NA#5	F 241	respond to knocking on door by the DON or Nurse Supervisor. 3. Measures put in place to ensure that the alleged deficient practice does not recur include: The Staff Development Coordinator or Director of Nursing will inservice Nursing staff regarding answering call lights in a timely manner to assist residents with their needs and respecting residents privacy by knocking before entering the residents room. Staff Development Coordinator (SDC) has inserviced Licensed Nurses on the provision and maintenance of dignity during med administration. Assigned department managers will monitor five (5) call lights and response times per day for three (3) weeks then five (5) weekly for four (4) weeks and at least one weekly there after during weekly rounds on going. Assigned department managers will monitor five (5) resident rooms daily for three (3) weeks then five (5) times per week for (4) weeks in regards to knocking on resident room doors on different shifts and report findings to IDT team Monday through Friday in IDT meeting. Nurse Managers will observe at least two Med pass observation weekly for four (4) weeks then two Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 241	Continued From page 2 said she did not remember the name of the other NA as she was new. When informed of the incident during an interview on 5/19/11 at 5:50 p.m., the Director of Nursing (DON) stated, "That's not acceptable." The DON revealed she expected staff to help each other but the resident should have been taken care of by the first NA who answered the call light. 2. Resident #5 was re-admitted to the facility on 09/01/10 with diagnoses including end-stage renal disease, high blood pressure and diabetes. A review of the quarterly minimum data set (MDS) dated 03/31/11 revealed the resident had no short term or long term memory problems, and no impairment in cognition. A review of the plan of care for pain revealed Resident #5's pain was related to recent dental work and chronic pain. Interventions included to administer analgesics as ordered. A review of a physician's order dated 04/29/11 revealed "swab mouth to assure resident has swallowed medication." During an interview on 05/19/11 at 2:07 p.m. Resident #5 stated he was told by second and third shift nurses they were instructed to swab his mouth after giving him pain medication because someone thought he was holding the pain medication in his cheek and not swallowing it. Resident #5 stated he had dental surgery about two (2) weeks ago, had stitches in his mouth and did not want anyone putting their fingers or a swab in his mouth. He stated it made him angry, he felt it was disrespectful and it was humiliating	F 241	(2) observations monthly ongoing for correct administration and correct medication. Concerns related to dignity or privacy will be reviewed daily Monday- Friday during IDT meeting and the Administrator will assign an appropriate follow up review from the department head team. The Administrator will review Resident council minutes monthly ongoing to identify concerns related to dignity and respect. Any concerns will be addressed by the Administrator or designated department manager. 4. Interdisciplinary Team (IDT) team will review the results of the observation; concerns and resident council minutes; evaluate the results for trends/patterns and report the results to the QA&A committee monthly for three months. The plan may be amended, by the QA&A committee, based on negative trends, to ensure continued compliance. 5. Date of completion June 16, 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 241	Continued From page 3	F 241		

to him. He further stated the weekend nurses were very strict about asking him to open his mouth for them to look and make sure he swallowed his medication and that was alright.

During an interview on 05/19/11 at 3:35 p.m., Licensed Nurse (LN) stated #7 she remembered Resident #5 was upset about having his mouth swabbed after receiving pain medication. She explained they were not convinced he was taking his medication and the physician's assistant and unit coordinator went into Resident #5's room and told him a nurse had concerns he was holding his medication in his cheek and not swallowing it. She stated he was upset because he did not want the nurses swabbing his mouth. LN #7 stated "I think it's humiliating for him. I think it's a dignity thing." She stated she didn't swab his mouth when she gave him pain medication but he swallowed the medication with soda and stuck out his tongue for her to check his mouth.

During an interview on 05/19/11 at 5:32 p.m. with the Director of Nursing (DON) she stated a second shift nurse was concerned that Resident #5 was holding his pain medication in his cheek and not swallowing it. She explained the nurse talked to the unit coordinator, discussed it with the nurse practitioner and an order was written to swab Resident #5's mouth to assure he swallowed his medication. The DON stated Resident #5 "kind of resented having his mouth swabbed and he had a right to be not so happy with that."

3. Resident #25 was admitted to the facility 12/7/10 with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Macular Degeneration. The

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F 241	Continued From page 4 most recent Minimum Data Set (MDS) dated 3/4/11 indicated no impairment of memory and cognition and dependence on staff assistance for daily care. On 5/19 at 10:35 a.m., the resident stated the nurse recently brought her the wrong medications and insisted she take them even after the medications were identified as the wrong ones. The resident stated she was visually impaired, but she could put the cup up to her face to see the contents. The resident insisted the medications were incorrect, and the nurse went back to the cart to verify the medications. The resident stated the nurse then admitted she brought her the wrong medications. The resident stated, "They just think all of us don't have any sense. But I still do!" The resident stated it made her feel "angry and frustrated" that the nurse wouldn't listen to her. The resident concluded the review of the situation stating, "She (the nurse) treated me like I didn't know what I was talking about and wouldn't listen to me. That's just not right." Continued resident interview revealed concerns with the nurses identifying themselves and their purpose when entering the room. The resident stated due to her severe visual impairment, she is unable to see the features of a person standing by the bed telling her what to do. The resident described feeling vulnerable in following the directions of someone when she could not see them. The resident reported the complaints to the corporate compliance line, but she had not received any response. The resident described the physical characteristics of the second shift nurse and identified her as the staff member involved in the incident.	F 241		

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F 241	Continued From page 5 On 5/19/11 at 4:15 p.m., Licensed Nurse (LN) #1 stated she regularly worked second shift and took care of Resident #25. The nurse stated she was uncertain if she had ever taken incorrect medications to the resident's bedside, but "maybe" she had. LN#1 stated medications should be given as ordered, and residents had the right to refuse. On 5/19/11 at 6:00 p.m., the Director of Nursing (DON) stated she expected staff to listen to residents and treat them with respect. The DON also stated staff should identify themselves to the resident each time they enter the room and explain their purpose is being there. 4. During the resident group meeting conducted on 05/18/11 at 11:20 a.m. six (6) of fourteen (14) residents reported staff do not always knock and they enter their rooms without waiting for permission to do so. They stated staff have no consideration for their right to wait for a response before entering their room. A follow up interview with a resident identified as interviewable by staff, who attended the group meeting, occurred on 05/19/11 at 8:58 a.m. At 9:04 a.m. observation was made of a staff member who opened the door without knocking and was about to enter the room without permission. She realized the resident was engaged in conversation and shut the door without identifying herself. Within a few more minutes, a staff member opened the door again without knocking and was about to enter the room without gaining permission and quickly closed the door and left. The resident stated she was bothered by staff not knocking or waiting for her	F 241		

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F 241	Continued From page 6 to respond before entering the room. An interview was conducted on 05/19/11 at 4:56 p.m. with the social worker about the procedure for entering resident rooms. The social worker stated she had one resident recently complain about staff not waiting for him to give permission to enter his room. The social worker revealed she notified staff of his preference and let them know they need to honor residents' right to wait to be invited into their rooms.	F 241		
F 242 SS=B	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and medical record review, the facility failed to honor food choices for one (1) of fifteen (15) sampled residents. (Resident #25) The findings are: Resident #25 was admitted to the facility 12/7/10 with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Macular Degeneration. The most recent Minimum Data Set (MDS) dated 3/4/11 indicated no impairment of memory and cognition and	F 242	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 25 has been interviewed to identify current likes and dislikes related to food and is served meals/food based on her choices. 2. Facility residents have the potential to be affected by the same alleged deficient practice, therefore the Dietary Manager has completed an audit of current likes and dislikes and interviewed residents and/or responsible parties to identify changes or additions to current information. 3. Measures put in place to ensure the alleged deficient practice does not recur include:Dietary Manager will provide inservice education for Dietary Staff on tray cards as they relate to resident likes and dislikes. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 242	Continued From page 7 dependence on staff assistance for daily care. The current Plan of care dated 3/12/11 addressed the problem of nutritional risk with interventions including, "Determine individual likes and dislikes/ Honor." On 5/19/11 at 10:35 a.m., the resident stated she had told staff about the problem but was frequently served foods she disliked. The resident stated she was served pizza the night before, and that was on her list of dislikes. The resident stated alternate foods were available, but it was "frustrating" to routinely receive foods she had specified as dislikes. On 5/19/11 at 12:30 p.m., the resident was observed during lunch service. Review of the tray card revealed a list of dislikes. The list of dislikes included cornbread, and cornbread was observed untouched on the tray. The resident stated no alternate bread was offered to her for lunch. On 5/19/11 at 4:55 p.m., Nursing Assistant (NA) # 4 stated the NA was responsible for checking the tray card against what the resident received and getting an alternate if the resident received something he/she didn't like. On 5/19/11 at 5:00 p.m., the Dietary Manager (DM) indicated a system was in place to check preferences and dislikes. The DM stated during tray line service, the diet order was checked and a Dietary Assistant at the end of the line checked the resident's food preferences against what is on the tray. The DM stated an additional staff member double checked the tray card against what was present on the tray to verify preferences and dislikes were honored. The DM was	F 242	Dietary Manager and/or assistant will monitor at least 3 trays during meals times daily Monday through Friday for four (4) weeks then five (5) per week for two (2) months for likes and dislikes on trays. Assigned department manager will monitor five (5) trays weekly for four weeks then two (2) trays weekly during administrative rounds ongoing to insure likes and dislikes are correct. The Dietary Manager will update food preferences upon admission, at least annually and when residents request changes to their information. 4. Dietary Manager will report findings to QA&A committee for review for three (3) months. The QA&A committee may amend the plan, based on negative trends to ensure continued compliance. 5. Date of completion June 16, 2011 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 242	Continued From page 8 uncertain why Resident #25 received foods specified as dislikes.	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to document dressing changes for two (2) of ten (10) sampled residents. (Residents #1 and #4) The findings are: 1. Resident #1 was readmitted 10/29/10 with diagnoses including hemiplegia, type 2 diabetes, and below-the-knee amputation. Review of the Wound Care Assessment forms in the medical record revealed the resident was seen by the wound physician for treatment of a lower extremity ulcer at the left ankle. Review of the May 2011 Medication Administration Record (MAR) revealed an order to clean the left ankle pressure ulcer and apply a topical antibacterial medication every day and as needed until healed. Review of the MAR revealed an initialed entry indicating wound care was provided 5/14/11. An interview with Licensed Nurse (LN) #1 on 5/19/11 at 4:00 p.m. revealed the resident refused his dressing change on 5/14/11. She said it was her usual practice to initial a record before doing a dressing change but she forgot to circle	F 281	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1 and # 4 by ensuring dressing changes are completed as ordered by the physician. 2. Residents with the potential to be affected by the same alleged deficient practice have been identified through: audit of medical records by the DON,RCMD or Nurse Supervisor to identify residents with dressing change orders. 3. Measures put into place to ensure the allege deficient practice does not recur include: Staff Development Coordinator (SDC) and Director of Nursing(DON) will provide inservice education for Licensed Nurses on proper procedure for caring for residents with dressing changes including documentation of completed treatments by initialing the Treatment Administration Record after completion of the dressing change. The SDC, DON, or Nursing Supervisor will monitor care for 2 residents; with dressing changes per day for 3 weeks then Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 281	Continued From page 9 her initials after his refusal. During an interview on 5/19/11 at 5:50 p.m., the Director of Nursing (DON) stated she expected nurses to document after the dressing changes were completed, not before. 2. Resident #4 was admitted 1/19/10 with diagnoses including chronic skin ulcer and osteomyelitis. Review of the resident's medical record revealed the resident was seen by the wound physician on a weekly basis for treatment of a left hip pressure ulcer. Review of the Physician's Telephone Orders revealed the following 4/27/11 order: "Begin on 4/28/11-Cleanse wound L [left] hip with wound cleanser spray, apply medi-honey, cover with dry dsg [dressing] or duoderm-change dsg QOD [every other day]." Review of the April 2011 Treatment Record revealed initialed entries indicating the daily dressing changes were completed as ordered. Review of the every other day dressing change order listed on the treatment record revealed an "X" recorded in the 4/29/11 space but no initialed entries for 4/28/11 and 4/30/11 to indicate the dressing changes were completed. During an interview on 5/19/11 at 9:40 a.m., the DON stated the medi-honey was available on 4/28/11 and the dressings should have been done as ordered. A telephone interview was conducted with Licensed Nurse (LN) #8 on 5/19/11 at 11:53 a.m.	F 281	weekly for two (2) weeks then monthly for three (3) months. 4. SDC, DON or Nursing Supervisor will report their findings to the QA&A committee for review monthly for three (3) months. The plan may be amended, by the QA&A committee based on negative trends, to ensure continued compliance. 5. Date of completion June 16, 2011 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 281	Continued From page 10 LN #4 stated she recalled changing the dressing on 4/28/11 but forgot to document the dressing on the Treatment Record. The nurse who provided care to the resident on 4/30/11 was unavailable for interview.	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 interviews and record reviews the facility failed to start an antibiotic medication as ordered and failed to provide wound treatment as ordered for one (1) of fourteen (14) sampled residents. (Resident #1) The findings are: a. Resident #1 was readmitted 10/29/10 with diagnoses including hemiplegia, type 2 diabetes, and below-the-knee amputation. The most recent Minimum Data Set (MDS) dated 3/21/11 revealed intact cognition and dependence on staff assistance for activities of daily living. Review of the Wound Care Assessment forms in the medical record revealed the resident was seen by the wound physician for treatment of a lower extremity wound at the left ankle. Review of	F 309	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1 by ensuring antibiotic has been administered as ordered by the physician. Resident #1's wound treatments are completed as ordered unless resident refuses. Nurse will document refusals of wound care by resident #1 and report to attending physician for additional direction and/or orders if continued refusals of care occur. 2. Residents with the potential to be affected by the same alleged deficient practice have been identified DON and Nurse Supervisor through audit of physician orders for antibiotics for the last thirty (30) days. 3. Measures put in place to ensure that the alleged deficient practice does not recur include: Staff Development Coordinator and/or Director of Nursing will provide inservice education to licensed Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 309	Continued From page 11 the Wound Care Assessment form dated 3/24/11 revealed the physician's order for a bone scan of the left foot and ankle due to a history of osteomyelitis. Review of the Physician's Telephone Orders revealed a 3/28/11 order for the bone scan written by Licensed Nurse (LN) #8. Review of the bone scan results of 4/1/11 revealed severe peripheral vascular disease and suspicion of osteomyelitis. Review of the Wound Care Assessment form dated 4/7/11 revealed the physician noted the bone scan findings and ordered treatment with levofloxacin (antibiotic) 500 milligrams daily for six (6) weeks. Review of the resident's medical record revealed a Physician's Telephone Order for the antibiotic dated 4/14/11. Continued review of the telephone orders revealed no documentation of an order for the antibiotic prior to the 4/14/11 order. Review of the Medication Administration Record (MAR) for April 2011 revealed the resident received the first dose of the antibiotic on 4/14/11. Interview on 5/18/11 at 11:53 a.m. with LN #8 revealed the wound physician completed visits and documented her assessments and orders in the computer. The Director of Nursing (DON) accessed and printed the Wound Care Assessment forms from the computer, and within the next day or two placed the forms in the resident's chart. LN #8 said once the forms were printed and placed on the chart, they generated written orders based on the documentation of the wound physician. LN #8 said she recalled the incident with Resident #1's antibiotic order because the doctor mentioned during the 4/7/11 visit that she was	F 309	Nurses in processing and carrying out physician orders. Nurse Managers will review new orders weekly with wound care physician during weekly visit for four weeks then monthly for three (3) months during Interdisciplinary Team meeting to ensure orders are written and noted to Medication Administration Record and/or Treatment Administration Record. 4. Director of Nursing (DON) or Nurse Supervisor will review findings for trends/patterns and report findings to QA&A committee monthly for review for three months. The plan may be amended, by the QA&A committee, based on negative trends, to ensure continued compliance. 5. Date of completion June 16, 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 309	Continued From page 12	F 309		

considering making changes in his treatment and placing him on an antibiotic. The nurse said she waited to see the forms for the orders, and this was the common practice for processing orders from the wound doctor. LN #8 said when the doctor came back on 4/14/11, the doctor asked her how the antibiotic was working for the resident and was then informed the resident was not receiving an antibiotic.

During an interview on 5/18/11 at 12:15 p.m., the DON said she was the only person at the facility who had access to the Wound Care Assessment forms completed with each wound visit. The DON stated she did not recall when she printed the Wound Care Assessment form for the 4/7/11 visit.

Interview with the wound care physician on 5/19/11 at 10:20 a.m. revealed she understood there was a problem with the order being accessed by the DON. The physician reported she came to see Resident #1 on 4/14/11. When the physician asked the nurse how the resident was doing with the antibiotic, she was informed the antibiotic had not been started. The physician also stated the resident's ulcer was chronic, and the delay in receiving the antibiotic was not harmful.

b. Review of the wound physician's order dated 4/14/11 indicated daily dressing changes with Bactroban to left ankle wound.

Review of the May 2011 Medication Administration Record (MAR) revealed the treatment to the wound on the left ankle was initialed and circled as not completed for 5/5/11

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F 309	Continued From page 13 and 5/13/11. Review of the nursing documentation on the back of the form dated 5/13/11 revealed the resident refused his dressing changes. Further review of the form revealed there was an initialed entry for 5/14/11 indicating treatment was completed as ordered. Interview with the resident on 5/17/11 at 5:05 p.m. revealed a concern about his dressings not being changed every day. The resident said his dressing was changed Thursday, May 12th and was not changed again until Sunday, May 15th. During an interview on 5/19/11 at 7:50 a.m., Licensed Nurse #2 stated the resident was out of the facility for most of her shift on 5/13/11. The nurse said after he returned to the facility, she told him she was going to do his dressing change, but he told her to leave him alone. An interview with Licensed Nurse #1 on 5/19/11 at 4:00 p.m. revealed she had not done the dressing change on 5/14/11 because the resident did not want it done at that time. During an interview on 5/19/11 at 5:50 p.m., the Director of Nursing stated she expected nurses to provide wound treatments as ordered by the physician.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	1. Corrective action has been accomplished for the alleged deficient practice in regards for Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 312	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility staff failed to provide mouth care for one (1) of fourteen (14) sampled residents who were dependent for care. (Resident #10) The findings are: Resident #10 was admitted to the facility on 08/10/09 with diagnoses of respiratory failure, stroke and sepsis. A review of the quarterly Minimum Data Set dated 05/02/11 revealed the resident had short and long term memory problems, severe impairment in cognition and required total dependence on staff for personal hygiene. A review of the plan of care for activities of daily living dated 05/10/11 revealed an intervention to provide oral care every shift and as needed. A review of the plan of care for nutrition dated 02/24/11 revealed Resident #10 received all nutrition by tube feeding. A review of the nurse aide assignment sheet dated 05/18/11 for Resident #10 revealed oral care should be provided every shift and as needed. Observation on 05/17/11 at 5:55 p.m. revealed Resident #10 was lying in bed with her eyes closed, breathing with her mouth open and thick white material was coated on her front teeth.	F 312	Resident #10 by providing mouth care each shift and as needed. 2. Residents who are dependent for activities of daily living, including mouth care, have the potential to be affected by the same alleged deficient practice; have been identified by the Resident Care management Director through audit of the MDS assessments for oral care needs by staff. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator Director of Nursing or Administrator will provide inservice education for Nursing staff on providing oral care for dependent residents. Assigned department managers will monitor four (4) dependent residents daily Monday through Friday for three weeks then weekly for three (3) months to identify that oral care needs are met. 4. Director of Nursing will review findings for trends/patterns and report to QA& A committee monthly for review for three (3) months. The plan may be amended, by the QA&A committee, based on negative trends, to ensure continued compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 312	Continued From page 15 Observation on 05/18/11 at 10:21 a.m. revealed Resident #10 was lying in bed, breathing with her mouth open, and her tongue was coated with white material. Continuous observation on 05/19/11 from 7:58 a.m. until 10:58 a.m. revealed Resident #10 in bed with her eyes open and breathing through her mouth with thick strings of white mucus on her tongue and in her mouth. At 10:25 a.m. revealed Resident #10 was taken into the shower room for a shower and at 10:50 a.m. Nursing Assistant (NA) #8 took a swab with toothpaste on it to clean Resident # 10's mouth and removed thick mucus from her teeth and tongue. During an interview on 05/19/11 at 9:27 a.m., NA #8 stated the NA's checked on Resident #10 this morning "to see if she was comfortable and alright" but they had not provided any personal care for her. During an interview on 05/19/11 at 11:02 a.m., NA #8 stated she usually provided mouth care to Resident #10 in the morning and again before she finished her shift. She explained she was not sure if mouth care was provided to Resident #10 by any other staff members. During an interview on 05/19/11 at 5:07 p.m., the Director of Nursing stated it was her expectation for Resident #10 to receive mouth care routinely using flavored swabs.	F 312	5. Date of Completion June 16, 2011	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 322	1. Corrective action has been accomplished for Resident # 10 and Resident # 16 by ensuring that the	

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F 322	Continued From page 16 who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility staff failed to recap a feeding solution tubing when disconnected from the gastrostomy tube for two (2) of four (4) sampled residents. (Residents #10 and #16) The findings are: Review of facility procedure titled "Tube Feedings, gastric" from Lippincott, Williams and Wilkins dated 01/08/11 stated: To discontinue gastric feeding close the regulator clamp on the gavage bag tubing, and turn off solution. Cover the end of the feeding tube with its plug or cap to prevent leakage and contamination of the tube. 1. Resident #10 was admitted to the facility on 08/10/09 with diagnoses of respiratory failure, stroke, sepsis and a history of PEG (percutaneous endoscopic gastrostomy) site drainage with culture positive for multiple infectious pathogens. A review of the quarterly Minimum Data Set (MDS) dated 03/24/11 revealed the resident had short and long term memory problems and severe impairment in cognition.	F 322	feeding tube is capped when it is disconnected. 2. Residents requiring the use of tube feeding by gastrostomy , PEG tube, or J tube have the potential to be affected by the same alleged deficient practice the Director of Nursing has completed an audit of current residents requiring the use of Tube Feeding solution. 3. Measures put in place to ensure that the alleged deficient practice does not recur include: Staff Development Coordinator (SDC) or Director of Nursing (DON) will provide inservice education for Licensed Nurses on proper procedure for Feeding Tube care including the practice of capping the tubing for feeding solution to prevent contamination. SDC, DON or Nursing Supervisor will monitor 2 residents with tube feeding per day for three weeks then weekly for three (3) months to identify concerns related to use of capping of tube feeding when not in use. 4. SDC, DON OR nurse Supervisor will report results of rounds monthly for three months to the QA & A committee for tracking and trending. QA & A committee will Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 322	Continued From page 17 Review of the plan of care for nutrition dated 02/24/11 stated Resident #10 received all nutrition by tube feeding. Continuous observation on 05/18/11 from 10:17 a.m. until 10:42 a.m. revealed Resident #10 was sitting in a geri chair next to her bed when Licensed Nurse (LN) #4 entered the room at 10:17 a.m. to disconnect Resident #10's feeding tube prior to the resident being transferred to bed. LN #4 tried to pull the feeding tube apart but was unsuccessful. She took keys out of her pocket and pried the tubing apart. She draped the disconnected feeding solution tube over the top of the feeding pump pole with the end of the tubing uncapped. She pushed the feeding pump pole away from Resident #10 leaving the uncapped end of the tubing swinging back and forth, contacting the pump pole, the bottle of feeding solution and the feeding pump. On 05/18/11 at 10:42 a.m. LN #4 took the uncapped feeding tube off the pole and reconnected it without cleaning it. An interview on 05/18/11 at 10:43 a. m. with LN #4 confirmed she took her keys out of her pocket to push the feeding tubing back and pull it apart. She stated normally they have a little cap to put on the end of the feeding tube but she guessed it wasn't there and the tubing was left uncapped. On 05/19/11 at 9:50 a.m. LN #4 disconnected Resident #10's gastrostomy tube from the feeding solution tubing to transfer the reside to a shower chair. LN #4 draped the uncapped feeding solution tubing over the feeding pump pole and walked out of the room.	F 322	review the findings and may amend the plan, based on outcomes, to ensure continued compliance. 5. Date of completion June 16, 2011 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 322	Continued From page 18 On 05/19/11 at 9:54 a.m. LN #4 re-entered Resident #10's room with a small plastic bag, placed the uncapped end of the feeding tube into the bag and taped it to the feeding pump pole. An interview on 05/19/11 at 3:59 p.m. with the staff development coordinator revealed LN #4 should not have draped the uncapped feeding solution tubing over the feeding pump pole. During an interview on 05/19/11 at 5:07 p.m. the Director of Nursing stated it was her expectation the nurses would put a cap on the end of feeding solution tubes when they are disconnected and feeding tubes should not be left hanging uncovered. 2. Resident #16 was admitted to the facility with diagnoses which included cerebrovascular accident, PEG (percutaneous esophageal gastrostomy) tube dependent, diabetes mellitus Type II, hypertension, chronic atrial fibrillation and seizure disorder. The admission Minimum Data Set (MDS) dated 03/24/2011 indicated the resident had severe cognitive impairment with short term and long term memory deficit. On 05/19/2011 at 7:40 a.m. Licensed Nurse (LN) #1 was observed administering medications to Resident #16 through the PEG tube. LN #1 turned off the pump and disconnected the feeding solution tubing from the catheter lumen on the PEG insertion line. She placed the uncovered end of the feeding solution tubing on the incontinence pad on the bed. She then proceeded to check for PEG tube placement and to administer the medication through the PEG line. When she	F 322		

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F 322	Continued From page 19 finished flushing the PEG line, she reconnected the feeding solution tubing to the catheter lumen on the PEG line. An interview with LN #1 on 05/19/2011 at 12:35 p.m. regarding using universal precautions and clean technique when giving medications through the tube revealed that the end of the tube should have been covered. She stated, "There's a little plastic cover on the tubing that usually gets thrown away when the feeding is connected. I guess we should keep it to cover the tubing when we have to disconnect it." An interview with the Director of Nursing on 05/19/2011 at 5:08 p.m. revealed her expectation is that the end of the feeding solution tubing is covered every time it is disconnected from the PEG line.	F 322		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 328	1. Corrective action has been Accomplished for the alleged deficient practice in regards to Resident # 10 by having a suction machine set up and ready for use during tracheostomy care and documenting oxygen saturation rates per the physician order. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 328	Continued From page 20 interview the facility staff failed to set up a suction machine prior to and during tracheostomy care and failed to document oxygen saturation percentages in one (1) of two (2) sampled residents. (Resident #10) The findings are: 1. Review of facility procedure dated 01/08/11 from Lippincott Williams and Wilkins titled "Tracheostomy tube cannula and stoma care" listed in part equipment and supplies including suctioning and stated "keep these supplies in full view in the patient's room at all times for easy access in case of emergency." It also stated under implementation, "using sterile technique, suction the entire length of the tracheostomy tube to clear the airway of any secretions that may hinder oxygenation." a. Resident #10 was admitted to the facility on 08/10/09 with diagnoses of respiratory failure, stroke, and sepsis. A review of the quarterly Minimum Data Set dated 03/24/11 revealed the resident had short and long term memory problems and severe impairment in cognition. A review of monthly treatment records revealed Resident #10 was to receive tracheostomy (trach) care every shift. A review of the plan of care dated 05/10/11 listed "respiratory" as a problem with interventions to provide trach care as ordered and suction as indicated. Observation on 05/18/11 at 2:03 p.m. revealed Resident #10 was sitting in a geri chair beside the	F 328	2. Residents who require Tracheostomy care have the potential to be affected by the same alleged deficient practice and have been identified by the Director of Nursing through audit of medical records to identify residents for use of Tracheostomies. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator, Respiratory Therapist and/or Director of Nursing will provide inservice education on Tracheostomy Care. SDC, DON or Nursing Supervisor will monitor care for two (2) tracheostomy care residents per week for three (3) weeks then weekly for three (3) months. SDC, DON or Nurse Supervisor will also monitor Medication Administration Record/ Treatment Administration Record for documentation of oxygen saturation Q weekly shift for four (4) weeks. 4. SDC, DON or Nursing Supervisor will report findings to the QA & A committee monthly for review for three (3) months. The plan may be amended by the QA&A committee, based on Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 328	Continued From page 21 foot of her bed with the curtain drawn down next to her. A suction machine was observed sitting on top of a bedside table covered with plastic at the head of Resident #10's bed. Licensed Nurse (LN) #4 stood at the foot of the bed with her back to the suction machine and the curtain behind her. She placed a towel and tracheostomy supplies on top of an overbed table beside Resident #10, washed her hands, put on gloves, and removed the aerosol trach collar and a soiled dressing from around Resident #10's tracheostomy tube. She removed her gloves, washed her hands and put on sterile gloves. She cleaned around the tracheostomy tube and applied a sterile gauze dressing around it. She removed the inner cannula in the tracheostomy which was coated with thick white mucus, discarded it in the trash and inserted a new sterile cannula into the tracheostomy. She discarded trash, washed her hands and reapplied the aerosol trach collar to the front of Resident #10's tracheostomy tube. During an interview on 05/18/11 at 2:11 p.m. LN # 4 stated sometimes she suctions Resident #10 when she does tracheostomy care. She confirmed the suction machine was on the overbed table behind her, covered in plastic and the suction catheter was inside the bedside table. An interview on 05/19/11 at 3:59 p.m. with the staff development coordinator revealed a suction machine should be set up and ready for use if needed during tracheostomy care. She also stated suctioning should have been done before the procedure to ensure the resident's airway was clear.	F 328	negative trends, to ensure continued compliance. 5. Date of completion June 16, 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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During an interview on 05/19/11 at 5:07 p.m. the Director of Nursing stated it was her expectation the suction machine should be set up and ready for use during tracheostomy care in case of an emergency.

b. A review of physician orders dated 03/09/11 for Resident #10 revealed "cool aerosol trach collar (room air) cont. bleed in oxygen at three (3) liters per minute for oxygen saturation less than or equal to ninety percent."

A review of the plan of care dated 05/10/11 listed "respiratory" as a problem with interventions to check pulse oximetry as indicated and administer oxygen as ordered.

A review of the monthly treatment record revealed staff initials were documented on the treatment record for each shift daily but there were no oxygen saturation percentages documented for any of the three shifts from 05/01/11 to 05/19/11 and there was no documentation regarding whether oxygen had been administered.

During an interview on 05/19/11 at 3:57 p.m. with Licensed Nurse (LN) #4 revealed she usually checked Resident #10's oxygen saturation percentage at the beginning of her shift but she does not write the percentage down. She further stated she could not remember the saturation percentage when she last checked it for Resident #10.

An interview on 05/19/11 at 3:59 p.m. with the staff development coordinator revealed nursing staff should document oxygen saturation

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F 328	Continued From page 23 percentages on Resident #10's treatment record so they know when to administer oxygen according to the physician's order. She confirmed there were no oxygen saturation percentages documented on the monthly treatment record and staff had only documented their initials for each shift. During an interview on 05/19/11 at 5:07 p.m. the Director of Nursing stated it was her expectation for nursing staff to check oxygen saturation percentages for residents with a tracheostomy or oxygen and they should document oxygen saturation percentages on the treatment record every shift.	F 328		
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. 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	F 329	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 15 by acting upon pharmacist recommendation for discontinuation of the identified medication and the physicians approval for discontinuation of Gabapentin as reflected in the residents administration record on 5/20/2011. 2. Residents with the potential to be affected by the same alleged deficient practice have been identified by the Director of Nursing through an audit of Pharmacy Recommendations for last 60 days. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 329	Continued From page 24 drugs. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to follow up on the consultant pharmacist's recommendation and the subsequent physician's approval to discontinue a duplicated medication. Duplicate medications Gabapentin (Neurontin) and Lyrica were administered after the physician accepted the pharmacist's recommendation to discontinue Gabapentin for one (1) of twenty one (21) sampled residents reviewed for Medication Monitoring Reviews. (Resident #15) The findings include: Resident #15 was admitted to the facility on 2/26/2007 with admitting diagnoses including Neuropathy, Neurogenic bladder and Acute Renal Failure. A review of the medical records included physician orders dated 3/10/2010 for Gabapentin (Neurontin) 600mg (milligram) three times daily by mouth for Neuropathic pain and also had an order dated 1/25/2011 for Lyrica 50mg three times daily with the same indication. Further review of the Monthly Medication Reviews (MMRs) dated 3/15/2011 by the consultant pharmacist, revealed a note documenting the duplicate medication therapy. The consultant	F 329	3. Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator (SDC) and/or Director of Nursing (DON) will provide inservice education for Licensed Nurses on proper procedures for processing Pharmacy Recommendations. DON or Nurse Supervisor will review the results of Pharmacy consult recommendations on a monthly ongoing basis to ensure that completed recommendations are acted upon timely and orders are transcribed for the approved recommendations. The consulting pharmacist will review medical records monthly on a ongoing basis and make note of recommendations that are not followed up by the physician to the Director of nursing to follow up timely. 4. SDC, DON or Nursing Supervisor will report of the Pharmacist consultant report findings to the QA & A committee for review monthly basis. The plan may be amended based on negative findings for continued compliance. 5. Date of completion June 16, 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 329	Continued From page 25 pharmacist during this March 2011 monthly review identified the discrepancy and recommended to the physician to re-evaluate the duplicate use. Accepting the recommendation of the pharmacist, the physician ordered to discontinue Gabapentin from 3/15/2011. A continued review of the Medication Administration Records (MAR) for the months of March 2011, April 2011 and May 2011 revealed that this discontinuation order was not processed resulting in Resident #15 receiving both Gabapentin and Lyrica all of March 2011, April 2011, and May 2011. An interview with the Licensed Nurse #7 (LN #7) on 5/19/2011 at 4:35 PM who administered the medications revealed, if the medication was discontinued the inventory on the medication cart would be removed to send it back to pharmacy for credit. In case of Resident #15, as far as she knew Gabapentin was not discontinued and confirmed that Resident #15 got Gabapentin 600mg three times daily and Lyrica 50mg three times a daily. An interview with the Director of Nursing (DON) on 5/19/2011 at 4:40 PM confirmed once the pharmacy recommendations were accepted by the physician, it was the responsibility of the floor nurse or the supervisor to transcribe the order as a telephone/oral order and pull the discontinued medications from the medication cart after completing the paper work in the MAR. The interview revealed that she was not aware that the discontinued order for Resident #15 was not processed and acted upon.	F 329		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=E	Continued From page 26 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep a ventilation hood above a food preparation area clean, replace the gasket sealing the door to the walk-in freezer, and remove open, undated frozen food from the freezer. The findings are: 1. An initial tour of the kitchen was conducted on 05/17/11 from 10:45 a.m. to 11: 04 a.m. The hood vent above the cooking stove area was observed on 05/17/11 at 10:46 a.m. with brown stained drip tracks on approximately ten vertical hood panels and a moderately thick build up of grease and grime in between the hood panels. An interview was conducted on 05/17/11 at 4:05 p.m. with the certified dietary manager. She stated the hood vents were cleaned by an outside vendor at least two times a year. She said the vendor usually placed a sticker on the hood after they clean it.	F 371	1. Corrective action has been accomplished for the alleged deficient practice by the hood vent being cleaned and gasket being replaced on freezer door and all outdated products removed from kitchen. 2. Facility residents have the potential to be affected by the same alleged deficient practice therefore the Dietary Manager has conducted a sanitation audit to identify additional concerns related to cleanliness, maintenance needs or expiration date and labeling of food items. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Dietary Manager will provide inservice education to dietary staff on cleaning of equipment including hood vent, outdated products and freezer storage. Dietary Manager or assistant will monitor freezer door 5 times per week for 3 weeks then weekly for 4 weeks and monthly thereafter. Dietary Manager will monitor freezer storage for open containers and out dated products for five (5) times per week for three (3) weeks then weekly for three (3) months. The maintenance director Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 371	Continued From page 27 Observation of the hood at this time, with the dietary manager, revealed sticker residue where a sticker had once been. There was no evidence that a recent sticker had been placed on the hood. The dietary manager did not know why a sticker had not been placed on the hood. She had no idea when the hood had last been cleaned by the vendor. The dietary manager reported that after the vendor thoroughly cleaned the hood and vents the maintenance director was supposed to clean it once a month. She stated she had requested maintenance to clean the hood and vents two weeks ago. The dietary manager confirmed the hood and vents should have been cleaned. An interview was conducted with the the maintenance director on 05/17/11 at 5:02 p.m. He stated the company comes every six months to clean the hood and vents. He said the last time they came was in January and probably would be coming in July. He did not have paper work available to show when they last cleaned the hood and vents. The maintenance director said after the company thoroughly cleaned the hood and vents he cleaned them every three months at night. He stated that grease builds up and can accumulate quickly, however, he was unable to provide information when he last cleaned the hood vents and panels. 2. The freezer was observed on 05/17/11 at 11:00 a.m. and 05/19/11 at 8:27 a.m. with the door partially opened. The door was observed not to close because the entire gasket on the door frame was missing. Large chunks of ice chips were observed on the freezer floor where	F 371	will monitor cleanliness of the hood vent monthly on a ongoing basis between scheduled contracted cleanings and provide assistance as needed to ensure compliance. 4. Dietary Manager will report their findings of the sanitation rounds to the QA & A committee for review monthly. The plan may be amended, by the QA&A committee based on negative trends, to ensure continued compliance. 5. Date of completion June 16, 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 371	Continued From page 28	F 371		

the door was partially opened.

An interview was conducted on 05/17/11 at 11:00 a.m. with the dietary manager. The dietary manager stated the entire gasket around the freezer door frame had been missing for several months and the door has not been able to be sealed. Temperature taken of the freezer was -8 degrees Fahrenheit. She revealed she has brought up the issue at monthly safety meetings and stated the maintenance director has known about the missing gasket at least since July, 2010. The dietary manager stated he had been coming twice a week to chip the built up ice off the freezer floor. In addition, she reported the maintenance director provided two metal strips observed to be approximately two inches wide and six inches long and attached them to the top of the freezer to try and seal the door but they have not worked. She reported she has talked with the maintenance director and he told her the gasket had been replaced about a year ago. Also, the dietary manager said she filled out a maintenance repair request for repair of the gasket which the maintenance director picks up to know what needs to be repaired. The dietary manager stated she keeps a copy of the repair request but was unable to locate it at this time.

An interview was conducted on 05/19/11 at 3:05 p.m. with the maintenance director. He stated a gasket had been replaced on the freezer approximately one year ago. He was told the gasket was completely gone off the freezer door frame. He stated the reason the door does not close was because the door was deteriorated at the bottom. He confirmed he comes to the kitchen twice a week and chipped off ice from the

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F 371	Continued From page 29 freezer floor trying to keep it clean. He did not think the problem with the freezer door was as "bad as it is or hurting anything." 3. Observations on 05/17/11 at 11:00 a.m. and 05/19/11 at 8:27 a.m. revealed ice build up and condensation on the freezer shelf closest to the door. One five pound bag of french fries and one five pound bag of tater tots, unused, were wet from the condensation. In addition, the five pound bag of tater tots had holes in the bag and was open to air. An interview was conducted on 05/1911 at 8:27 a.m. with the dietary manager. She observed the five pound bag of french fries and the five pound bag of tater tots with condensation on them and the holes in the bag of tater tots. She said the dietary assistant stocked the freezer once a week, labeled and dated foods when opened, and discarded foods which were out of date or open to air. The dietary manger stated she probably missed the bag of tater tots and it should have been discarded. The dietary manager was observed to take both bags out of the freezer and discard them.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 26 by obtaining medications for administration as ordered. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 425	Continued From page 30 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, facility record reviews and staff interviews the facility failed to obtain scheduled medication (Oxybutynin ER) for one (1) of twelve (12) sampled residents observed for medication administration. (Resident #26) The findings include: 1. A review of the facility Medication Administration policy SSP 0603.00 revised in June 2008 included that all medication orders were to be started timely and the routine medication orders to be started on the same day. The policy also included instructions to staff members to follow up on the faxed refill orders or new orders if there were any issues with the provider pharmacy and obtain medications using the backup pharmacy procedures. Resident #26 was admitted to the facility on 12/3/2008 had admitting diagnoses including overactive bladder, Hypertonicity of bladder, Diabetes Mellitus-II, Deep Vain Thrombosis and	F 425	2. Residents with the potential to be affected by the same alleged deficient practice have been identified through audit of Medication Administration Record to medications in cart by the Staff Development Coordinator and/or pharmacy representative. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator, Pharmacy Consultant and Director of Nursing will provide inservice education for licensed nurses on ordering, reordering of medication and tracking orders medication to ensure medication are available for administration as ordered. SDC, DON and Nursing supervisor will review new orders daily Monday through Friday, and validate receipt of medication from the pharmacy via delivery ticket on at least 25 orders per week. The Director of Nursing, Staff Development Coordinator or Nurse Supervisor will audit availability concerns at least weekly for three months then monthly ongoing. Licensed nurses will notify pharmacy in the event that medications are not available for administration and utilize back up systems to obtain medications, Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 425	Continued From page 31 history of strokes causing Dysphagia and Dysarthria. A review of the medical records for Resident #26 revealed a physician order dated 12/03/2008 for 'Oxybutynin Chl ER 10mg tab ie: (that is) Ditropan XL Take 1 Tab by mouth Every Day' and it was renewed each month including for May 2011. Resident #26 was observed for medication administration on 5/18/2011 at 8:15 AM in 200-hall. Licensed Staff #5 (LN #5) was observed administering medications to Resident #26. LN #5 stated that medication Oxybutynin 10mg (milligram) ER (Extended Release) which was scheduled to be given was not on the cart. She stated that she would check the back up room and administer the medication later. LN #5 completed the medication administration to Resident #26 except Oxybutynin ER tablet. An interview with LN #5 on 5/18/2011 at 8:30 AM revealed that she was not sure if Oxybutynin ER 10mg for Resident #26 had been reordered and could not show any documentation for having reordered. LN #5 stated that the reorder of medications was always done when 5-6 tablets were left on the medication card per pharmacy instructions. Later on 5/18/2011 at 10:05 AM LN #5 confirmed that Oxybutynin ER 10mg had not been reordered from the pharmacy and she made arrangements to obtain following backup pharmacy procedures immediately. An interview with the Director of Nursing (DON) on 5/19/2011 at 8:40 AM revealed that it was her expectation that all medications had to be reordered when 5-6 tablets were left on the	F 425	these incidents will be reported the Director of Nursing for additional follow up as needed. 4. SDC, DON or Nursing Supervisor will report there findings to the QA & A committee monthly. The plan may be amended, by the QA&A committee based on negative trends, to ensure continued compliance. 5. Date of completion June 16, 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 425	Continued From page 32 medication card. The DON also stated that all nurses were expected to follow up on the faxed, new or reordered medications related to any pharmacy supply issues. A telephone interview was conducted with the pharmacist at the provider pharmacy on 5/19/2011 at 10:47 AM. The interview revealed that all new or reorders faxed prior to the cut-off of time of 5:00 PM were delivered on the same day late evening. For Resident #26 Oxybutynin ER 10mg was requested on 5/17/2011 and per the refill history it was last refilled on 7/30/2010 and no other refill information was available. The pharmacist also stated that there was an on-call pharmacist during off hours, to make arrangements to obtain medications from the backup pharmacy if needed.	F 425		
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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 10 by discarding the open container. Handwashing occurs, as appropriate during incontinence care for Resident # 12. 2. Facility residents have the potential to be affected by the same alleged deficient practice, therefore the Director of Nursing and Staff Development Coordinator has initiated skills validation for Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/GASTO	969 COX RD GASTONIA, NC 28054

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F 441	Continued From page 33 (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, record review and staff interview the facility staff failed to discard an open container of petroleum jelly that fell on the shower room floor prior to using on a resident's hair and lips (Resident #10) and wash their hands during incontinence care (Resident #12) for two (2) of seven (7) sampled residents. Findings are: 1. Resident #10 was admitted to the facility on 08/10/09 with diagnoses of recurrent urinary tract infections, sepsis, pressure ulcers, and respiratory failure. A review of the quarterly Minimum Data Set dated 03/24/11 revealed the resident had short and long term memory	F 441	resident care specialist related to handwashing. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Staff Development Coordinator, and Director of Nursing will provide inservice education on infection control in regards to incontinence care and disposing of contaminated products to Resident Care Specialist (RCS) . SDC, DON, Nurse Supervisor and Charge nurses will observe RCS until each RCS has been observed on three (3) incontinence care rounds, then SDC, DON, Nurse Manager or Charge Nurse will observe at least three (3) RCS monthly on going. SDC will educate and inservice new RCS on incontinence care and SDC, DON, Nurse Supervisor and Charge Nurses will monitor three (3) incontinence care rounds during orientation. SDC, DON and Nurse Supervisor will monitor ADL care for three (3) residents weekly for three (3) weeks then monthly thereafter for proper care related to infection control procedure of discarding contaminated products. 4. SDC, DON or Nursing Supervisor will report findings of skills Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 441	Continued From page 34 problems and severe impairment in cognition. She required extensive assistance from staff for bathing and personal hygiene. A review of the plan of care for activities of daily living for Resident #10 revealed she required total care with one (1) to two (2) staff members and interventions included staff to provide bathing, dressing, grooming and use lip ointment as needed. Observation on 05/19/11 at 10:25 a.m. revealed Nursing Assistant (NA) #1 and NA #8 transferring Resident #10 from the shower bed to a geri chair in the shower room. During the transfer an open container of petroleum jelly fell off the shower bed onto the floor next to the shower drain. NA #8 picked the container of petroleum jelly off the floor and with her finger removed some of the jelly from the container, put it in Resident #10's hair and combed it. NA #8 put her finger back into the jar and applied another application of petroleum jelly to Resident #10's lips. On 05/019/11 at 10:58 a.m. during an interview with NA #8 she stated she should not have used the petroleum jelly in the container after it fell on the shower room floor. She should have discarded the container. She stated she usually took individual packets of petroleum jelly to the shower room to use but didn't bring them with her today. During an interview on 05/19/11 at 5:07 p.m., the Director of Nursing (DON) stated NA #8 should not have used petroleum jelly from the container after it fell onto the shower room floor. The DON stated staff should have discarded the container	F 441	validation and care rounds to the QA & A committee for review monthly for three months. 5. Date of completion June 16 2011. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 441	Continued From page 35	F 441		

and not used its contents on Resident #10's hair or lips.
2. Resident # 12 was admitted to the facility with diagnoses which included cardiomyopathy, hypertension, dementia, chronic obstructive pulmonary disease and congestive heart failure. The admission Minimum Data Set (MDS) dated 04/27/2011 indicated Resident # 12 had moderate cognitive impairment and impaired short term and long term memory. The MDS further revealed the resident was frequently incontinent of bowel and bladder and required extensive assistance of staff with toileting.

On 05/17/2011 at 4:10 p.m. (Nursing Assistant) NA # 6 and NA # 7 entered Resident # 12's room to provide incontinence care. Both staff washed their hands and donned gloves prior to beginning care. Resident #12 was incontinent of stool. NA # 6 washed and rinsed Resident # 12's perineal area and placed the soiled washcloths on the overbed table. She then removed her gloves and placed them on the overbed table and donned clean gloves. During care, Resident #12 became soiled with another episode of bowel incontinence. NA # 6 removed her gloves and left the room to obtain more gloves, washcloths and incontinence pads. She did not wash her hands prior to leaving the room. When NA # 6 returned, she and NA # 7 washed Resident # 12, changed their gloves, dried Resident # 12's skin and applied barrier protective cream, changed their gloves and put an incontinence brief on Resident # 12. NA # 6 and NA # 7 did not wash their hands at any time while providing care until after care was completed. NA # 6 carried the bags of soiled linen and trash from the resident's room without wearing gloves. The overbed table was not

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F 441	Continued From page 36 cleaned or disinfected after the soiled items were removed. Review of the facility's policy and procedure on incontinence care revealed the following: "Dispose of soiled articles in the appropriate receptacle. Remove your gloves and perform hand hygiene. " An interview with NA # 6 on 05/17/2011 at 4:47 p.m. revealed she should have washed her hands before leaving the resident's room for more supplies. She further stated she should have cleaned the overbed table after placing the soiled items on it. An interview with NA # 7 on 05/17/2011 at 5:20 p.m. revealed the soiled gloves and washcloths should not have been placed on the overbed table but should have been placed in a trash bag. An interview with the Director of Nursing (DON) on 05/19/2011 at 5:08 p.m. revealed she expects staff providing incontinence care to wash their hands when entering the room, after cleaning the resident and before applying protective cream, before putting a clean incontinence brief on the resident and before leaving the room. She further stated soiled items such as gloves and washcloths should be put in plastic bags and removed from the room, not placed on the overbed table.	F 441		