STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF SCOTLAND NECK	920 JR HIGH SCHOOL RD SCOTLAND NECK, NC 27874

(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=G	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, staff, resident and family interviews and record review, the facility failed to maintain the dignity of 1 of sampled residents (Resident # 54) who was observed with flies on her body and unable to brush them off. Findings include: Resident # 54 was admitted on 11/10/09 with cumulative diagnosis of dementia and cerebrovascular accident with hemiparesis. An Annual Minimum Data Set (MDS), dated 06/04/11, indicated Resident # 54 had short and long term memory impairment and was severely impaired in cognitive skills for daily decision making. The MDS also indicated the resident was rarely or never able to understand others and had no speech. Resident # 54 was coded as totally dependent on staff for all activities of daily living. She was also identified as having functional limitation in range of motion unilaterally in her upper and lower extremities. On 8/22/11at 3:00 PM, an observation was made of flies crawling on Resident # 54's face and lips. The resident did not respond in any way. She was unable to brush the flies away.	F 241	*This Plan of Correction is the center's credible allegation of 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 law.* 1. Insect light and fly strip were placed in resident #54 room on 8/25/11. 2. In-service education for the Maintenance Director was provided by the Administrator on checking fly lights daily and contacting EcoLab as needed for maintenance of the fly lights. Facility staff were provided in-service education by the Administrator and Director of Nursing on observation of flies throughout the facility and reporting to the Administrator or Maintenance Director when flies are noticed on or around residents, in resident common areas, or in resident dining areas. Five additional insect lights were purchased from EcoLab. The facility now has ten insect lights. Two insect lights were placed in the lobby, two in the dining room, one in resident #54 room, one in the employee break room, one each on the north and south halls, one on the annex hall, and one extra to be placed if flies are noted elsewhere in the facility.	F 241 9/19/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DeShae Morse	Executive Director	9/9/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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GUARDIAN CARE OF SCOTLAND NECK	920 JR HIGH SCHOOL RD SCOTLAND NECK, NC 27874

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F 241	Continued From page 1 On 08/23/11 at 12:30 PM, an observation was made in the facility lobby. Each time the door was opened, flies came into the building. No fan, insect light or fly strip was seen in use to deter the flies from entering the building. Resident # 54's room was the first room on the left hall after entering the building An interview was held on 08/23/11 at 12:45 PM with Resident # 54's Responsible Party (RP) and 2 other family members. All family members agreed flies had been an issue for Resident # 54. One family member stated she had been in the facility one day recently and had to continually brush flies off the resident's face. The family member added during one of her visits, the Administrator came by with a visitor. She added she summoned the Administrator in the room to discuss the flies. The Administrator told her he would be back to talk with her later. The family member stated, "later has not come yet". Resident # 54's RP stated the resident was unable to do anything for herself and would not be able to brush flies off her face. The family members added they had been in the resident's room with fly swatters trying to kill the flies. The dinner meal was observed on 8/23/11 at 5:10 PM. Residents were observed brushing flies away from their food. One resident was observed with fly swatter in his lap. At 5:30 PM on 08/23/11, a nursing assistant (NA) was observed assisting with a resident's dinner. The NA told the resident that she, the NA, needed to sit there to keep the flies away. Review of the Grievance Log from 06/10 through 08/24/11 did not indicate any residents or family	F 241	*This Plan of Correction is the center's credible allegation of 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 law.* 3. The Administrator and the Maintenance Director will conduct facility rounds to identify flies and monitor the effectiveness of the insect lights daily x 2 weeks, 3 x week x 2 weeks, 2 x week x 4 weeks, then weekly x 4 weeks. 4. Results of these facility rounds will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

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F 241	Continued From page 2 members had complained of insects in the building. Review of the resident council minutes for June, July and August did not indicate concerns about flies in the building. An observation was made on 8/24/11 at 10:27 AM. No flies were seen in the resident's room. There was no fly strip positioned over the resident's window valance. An interview was held with the Maintenance Director (MD) on 08/24/11 at 10:48 AM. Pest control logs were reviewed. The MD stated the company responsible for pest control visited monthly. He added the facility had a large fly control program which included 5 fly lights that were located on each hall, the dining area, the employee break room and the lobby. The MD added the fly light in the lobby had been reinstalled that morning. The Administrator had asked that the fly light in the lobby be replaced on Monday morning (8/22/11). The MD stated that with residents opening and closing doors so much, flies were allowed to enter the building. The MD stated there was one resident about a year ago that complained there were flies, but the room mate did not. If a resident complains about flies, then a glue strip for flies was placed over the window valance. The MD stated he had not noticed flies in any particular resident rooms. An interview was held with NA # 3 on 8/24/11 at 2:29 PM. NA # 3 stated in the last few weeks she had seen flies in the dining room and in resident's rooms and on the resident's bodies. The NA named a particular resident who had trouble with flies, but added this resident could brush the flies away. NA # 3, who worked with Resident # 54 on	F 241		

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F 241	Continued From page 3 8/24/11 stated Resident # 54 was unable to brush flies away if they should land on her body. The NA stated she had not received complaints from residents, families or staff about flies. The NA acknowledged she had not reported her observations of flies in the dining area or on residents to anyone. An interview was held with the Administrator on 08/24/11 at 2:49 PM. The Administrator stated the fly light was in the lobby, but had been taken down a couple of months ago in order to do work. He added since there had been no problem with flies, there had been no hurry to put the fly light back up. The Administrator stated he had noticed a problem with flies increased a couple of days ago. He added flies could cause illnesses by spread of bacteria because they are nasty. The Administrator stated he had received no complaints about flies from residents or families in the last year. He stated he could not recall Resident # 54's family speaking to him about flies. The Administrator stated flies on a resident's face and mouth was disgusting. The Administrator acknowledged Resident # 54 had no ability to brush flies away independently. At this point, the Administrator stated nothing had been done to keep flies off dependent residents and at this time, he doesn't know what could be done. An interview was held with the Director of Nursing Services (DNS) on 08/24/11 at 3:35 PM. The expectation would be for the staff to get the flies off the resident and then report it to her or the Maintenance Director. The DNS stated she had not seen flies on any resident.	F 241		

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F 241	Continued From page 4 An observation was made on 08/24/11 at 5:30 PM in the dining room. Resident # 62 was observed continuously brushing flies away from his face. He stated the flies were a big bother. The resident had his fly swatter laying on the dining room table. He stated he had to keep swatting to keep the flies to keep them off his food. The resident stated flies were really bad in the building. The admission assessment for this resident, dated 07/19/11, indicated the resident was cognitively intact.	F 241	*This Plan of Correction is the center's credible allegation of 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 law.*	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	1. Resident #26 care plan was reviewed and updated by the interdisciplinary team (IDT) to include weight loss. Resident #52 care plan was reviewed and updated by the IDT to include seizures and refusal of medications. Resident #13 care plan was reviewed and updated by the IDT to include hospice care and contracture management. Resident #29 care plan was reviewed and updated by the IDT to include falls. 2. Residents experiencing weight loss or falls within the past 90 days, residents with seizure diagnoses, residents receiving hospice services, residents with contractures, and residents refusing medications within the past 90 days were identified through medical record review and staff interview. The care plans for these residents were reviewed and updated by the IDT to reflect personalized interventions for each resident's specific needs. Licensed nursing staff were in-serviced by the Director of Nursing on updating resident care plans as needed to accurately reflect acute issues, as well as the development and review of resident care plans on admission, quarterly, annually and with any significant change in	F 279 9/19/2011

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F 279	Continued From page 5 Based on observations, staff interviews and record review, the facility failed to develop a personalized plan of care that addressed nutritional needs, a seizure disorder, behaviors, contracture, hospice services and falls for 4 of 19 sampled residents (Residents # 13, 26, 29 and 52) whose care plans were reviewed. Findings include: 1. Resident # 26 was admitted on 07/31/08 and most recently readmitted on 06/17/11. Current diagnoses included acute cholecystitis, biliary drainage tube placement for gallstones, coronary artery disease, diabetes, congestive heart failure, dehydration, and anemia. The resident had been readmitted on 06/17/11 after placement of a biliary tube for gallstones in his gallbladder. Prior to his 06/10/11 hospital admission, the resident had experienced significant abdominal pain, anorexia, nausea and vomiting. The discharge summary indicated the drain would be left placed until there was less than 10 ml of drainage for 3 consecutive days. There was no care plan developed to address the resident's anorexia. Resident # 26's weight was recorded on the Nursing Assessment, dated 06/17/11 as 189 pounds. The assessment indicated Resident # 26 had no nausea or vomiting. He was assessed as alert and oriented, not confused and appropriate. Resident # 26 was documented as being independent with eating. The resident's care plan, dated 06/17/11, did not address the potential for weight loss or actual weight loss.	F 279	*This Plan of Correction is the center's credible allegation of 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 law.* condition. 3. The Director of Nursing will audit new admission care plans at the time of admission to validate appropriate care plan interventions have been identified and implemented. This audit will occur on-going with new admissions. The Director of Nursing will audit routine care plan updates as follows: 5 care plans per week x 8 weeks, then 10 care plans per month x 1 month. The Director of Nursing will review care plan updates for acute changes in condition 5 x per week during clinical rounds on-going. 4. Results of these care plan audits and reviews will be reported to the facility's Performance Improvement Committee monthly x 3 months for further review and recommendation.	

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F 279	Continued From page 6 The Medical Nutrition Therapy Assessment, dated 06/20/11, indicated the resident received a low concentrated sweet diet, regular texture and thin liquids. Average food intake was recorded as 100%. The assessment indicated the resident had a left above the knee amputation surgical site. Dining skills were recorded as independent. The assessment documented the resident's weight as 189 pounds. The Registered Dietician noted under COMMENTS, that Resident # 26 consumed adequate intake to meet nutritional needs. She did indicate increased protein needs were needed to promote healing of his surgical site. The Registered Dietician (RD) documented Resident # 26's diet provided 2100 calories and 90 grams of protein. The goal was to prevent significant weight change and maintain adequate hydration. Monitoring and evaluation would include food and beverage intake, weight change and skin condition. The RD indicated she would proceed to care plan related to the resident receiving a therapeutic diet. There were no care plan seen for the increased protein needs or the therapeutic diet. On 06/20/11, the physician indicated Resident # 26 would receive a large portion of meat and eggs per nutritional recommendation. The large portion of meat and eggs were not included in the care plan. An Admission Minimum Data Set (MDS), dated 06/24/11, indicated the resident was able to understand and be understood. Resident # 26 was assessed as moderately cognitively impaired. Resident # 26's weight was recorded as 189 pounds with no weight loss of 5% in the	F 279		

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F 279	Continued From page 7 previous month or 10% in the previous 6 months. The Nutritional Care Area Assessment (CAA) Summary, dated 06/30/11, indicated the resident had no nutritional problems, therefore, nutrition would not be care planned. On 07/04/11, a physician's order indicated the resident was sent to the hospital for evaluation of right side pain. Laboratory work performed during hospitalization, on 07/04/11, indicated an albumin of 2.7 (normal range 3.4 to 5.0). The low albumin and the large portion protein diet was not added to the care plan. The resident's weight was 178.2 on 07/05/11. A care plan was not developed for the potential for weight loss or the therapeutic diet. On 07/19/11, Resident # 26's weight was recorded as 175 pounds. No care plan was developed to address weight loss or a therapeutic diet. On 07/31/11, the resident's weight was 167.2. This reflected an eleven pound weight loss in 26 days. This indicated the resident had significant weight loss. No care plan was developed to address significant weight loss. No interventions were placed to prevent further weight loss. The low albumin and a high protein diet were not addressed on Resident # 26's care plan. On 08/10/11, Resident # 26's weight was recorded as 166.8 pounds. The continued weight loss and interventions to prevent weight loss were not added to the care plan.	F 279		

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

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F 279	Continued From page 8 An observation was made on 08/23/11 at 12:16 PM. The resident's tray card indicated he received standard portions. The resident had eaten 100% of his meal. An observation was made on 8/23/11 at 5:06 PM. The resident's tray card indicated standard portions. The resident was served a sloppy joe. The meat on his sandwich matched what other resident's received. The resident also received tater tots, baked beans and a fruit cup. Fluids included a glass of tea and water. An observation was made of breakfast on 08/24/11 at 8:00 AM. The resident received 1 boiled egg and 3 slices of bacon as protein. An interview was held with Resident # 26 on 08/24/11 at 8:35 AM. He stated he received the same amount of meat and eggs as everyone. An interview was held with Nursing Assistant (NA) # 3 on 08/24/11 at 3:21 PM. She was unaware Resident # 26 had been ordered large portions of meat and eggs. An interview was held with the Director of Nursing Services (DNS) on 08/24/11 at 3:35 PM. The DON stated she was unsure if Resident # 26 received a special diet. An interview was held with the DNS on 08/24/11 at 4:37 PM. She stated when a dietary order is received, a form is filled out with the diet order and sent to the dietary dept. The DON stated possibly the weight loss for Resident # 26 could have been prevented if he had received the double meat/egg portions. The extra protein was	F 279		

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F 279	Continued From page 9 needed for low albumin and wound healing. An interview was held with the Registered Dietician on 08/25/11 at 9:21 AM. The RD stated the recommendation was made for Resident # 26 to receive extra meat and extra eggs related to a healing surgical site. She added her expectation was to be notified of weight loss as soon as possible. Interventions placed to prevent further weight loss would depend on the resident involved. Sometimes, a resident may want to lose weight, sometimes the weight loss would be because the resident was eating a more balanced diet. The RD stated the intent of the 06/20/11 order was for Resident # 26 to receive large portions of meat and eggs at all meals and not just breakfast. The RD reviewed the weight record for Resident # 26 and acknowledged the weight loss from 07/05/11 to 08/10/11 equaled 6.4 % which was a significant weight loss. She stated that potentially not receiving the extra meat/eggs could have contributed to the weight loss. The RD stated she had not been aware of the significant weight loss until surveyors brought it to the facility's attention, therefore she had not care planned the weight loss. The RD stated she had spoken with the resident this morning who had expressed a desire for weight loss. She added based on the conversation, review of blood sugars and laboratory results, she felt no interventions were needed at this time. The RD stated she had reviewed the care plan for Resident # 26 and there had not been a care plan addressing nutritional issues. Resident # 26 was interviewed on 08/25/11 at 10:00 AM. He stated he was happy about losing weight and desired to lose about 10 more	F 279		

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F 279	Continued From page 10 pounds. An interview was held with the MDS Coordinator at 11:35 AM on 08/25/11. The initial care plan was the responsibility of the MDS department after the completion of the MDS. Updates are done quarterly or updated as significant events occurred if she was notified of the significant events. Significant events included the development of wounds, weight loss and falls. The MDS nurse added nutritional care plans were care planned by the dietary department. The RD was responsible for care planning a desire to lose weight, therapeutic diets and significant weight loss. 2. Resident #52 was admitted to the facility on 08/20/09 and readmitted on 12/31/09. The resident's documented diagnoses included seizure disorder, psychosis, and paranoia. A 02/01/11 5:30 PM resident progress note documented Resident #52 experienced seizure activity and was unable to speak for approximately one minute in the dining room. A 02/14/11 resident progress note documented, "_____ (name of family member) called. Made aware of (Resident #52) refusing medications...." A 02/16/11 resident progress note documented, "...(Resident #52) refused all medication this morning...." A 02/18/11 resident progress note documented, "Resident refused PM meds. No good reason given. Recommended another time to take	F 279		

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F 279	Continued From page 11 meds. Resident adamant, 'I'm not taking any meds.'" A 02/22/11 7:15 PM resident progress note documented Resident #52 began shaking and experienced seizure activity in the dining room which lasted approximately four to five minutes. A 03/19/11 resident progress note documented, "Resident refused to take meds. Her _____ (family member designation) tried to give her, she refused too...." Resident #52's 05/05/11 Quarterly Minimum Data Set (MDS) documented the resident suffered from severe cognitive impairment, exhibited verbal behavioral symptoms directed towards others, but did not resist or reject care. A 06/04/11 resident progress note documented, "Reported from night nurse that resident refused PM meds last night after (symbol used) many attempts per nurses...." A 06/04/11 12:30 PM resident progress note documented Resident #52 was eating lunch in the dining room when seizure activity, which lasted a little less than two minutes, began. Resident #52's 08/02/11 Annual MDS documented the resident suffered from severe cognitive impairment, exhibited delusional behavior, but did not resist or reject care. Review of Resident #52's care plan revealed the resident's problems of seizure activity and refusing medications were not identified.	F 279		

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F 279	Continued From page 12 At 4:55 PM on 08/24/11 Nurse #3 stated she had worked with Resident #52 since February 2011, and it was very difficult to get the resident to take her medications. This nurse reported it was very important to get the resident to take her PM medications because this was when the resident received her anti-seizure medications. She commented it seemed there was a pattern when the resident refused her PM meds, she experienced seizure activity the next day. She stated she thought the resident had two or three seizures since she had worked with her. Since February 2011, Nurse #3 reported Resident #52 refused PM meds about three or four times for her. She stated it was still an ongoing problem to get the resident to take medications, and most often, Resident #52 insisted another staff member had already given her medications. Therefore, the resident felt "duped" by the staff. According to Nurse #3, she attempted several approaches to help facilitate the resident taking her medications including involving the resident's family to offer encouragement, and asking other nurses on duty to also approach the resident about taking her medications. She reported sometimes these approaches were successful, and other times they did absolutely no good. At 11:23 AM on 08/25/11 Nurse #4 stated she had worked with Resident #52 since June 2011, and since that time the resident refused to take her medications approximately eight times. She explained she attempted to reapproach the resident several times after the initial medication pass failed, but if the resident still refused medicines, she did not force the resident to take these medications. However, she reported she documented that the resident did refuse all	F 279		

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F 279	Continued From page 13 attempts to administer medications. The nurse commented she tried showing the resident her pills because she could recognize them, but most times the resident still insisted she had already received them from another nurse. According to Nurse #4, she knew Resident #52 had one seizure since she worked with her, and thought she heard mention of several other seizures the resident experienced prior to her starting work in the facility. At 11:35 AM on 08/25/11 a floating MDS nurse stated the facility's full-time MDS nurse was out on leave. She explained although she had helped this facility out over the last three and a half years periodically, it was only within the last month that she returned to the building twice a week. She reported the MDS nurse created most care plans, but the social worker and dietary manager created care plans related to their areas of expertise. The nurse also commented the admitting nurse was responsible for creating the 24-hour, temporary care plans. According to the nurse, she was not aware that Resident #52 exhibited any behaviors. However, once she reviewed the resident's chart, she stated she saw documentation that Resident #52 refused medications. The nurse explained the refusal of medications should be captured on MDS assessments under rejection of care, and the social worker should create a care plan related to the resident's refusal of care. The floating MDS nurse commented she was unaware Resident #52 had active seizures, but the approaches for managing the resident's seizure activity should be documented in the care plan. She explained nursing would be responsible for addressing seizure management in the resident's care plan.	F 279		

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F 279	Continued From page 14 The nurse commented she was at a disadvantage because she did not attend morning stand-up meetings. At 12:15 PM on 08/25/11 the Director of Nursing (DON) stated Resident #52 refused her medications and sometimes refused to take baths. She reported she was unaware that Resident #52 experienced actual seizure activity. According to the DON, Resident #52's refusal of care and the management of the resident's seizure precautions should be addressed in the care plan. She explained the social worker was responsible for developing care plans related to behavioral issues such as refusing to take medications, and the MDS nurse was responsible for developing care plans related to seizure management. The DON reviewed Resident #52's care plan and acknowledged that refusal of care was not addressed, and that seizure management was not identified as a problem, with approaches developed to address the problem, even though seizure activity was mentioned in the activity and activities of daily living (ADL) care plan problems. At 1:10 PM on 08/25/11 the social worker stated she was responsible for developing care plans which addressed resident behaviors such as refusal of care. She reported she was made aware of residents exhibiting behaviors by reviewing MDS assessments and progress notes and talking with the staff. The social worker commented she was aware Resident #52 refused medications, hygiene care, and staff assistance. However, she stated she did not feel that these behaviors should be addressed in the resident's care plan because these were baseline behaviors	F 279		

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F 279	Continued From page 15 which the resident had exhibited since she was admitted. The social worker also commented the behaviors only occurred sporadically, and the resident was easily redirected. 3. a. Resident #13 was admitted to the facility on 01/01/11 with diagnoses of chronic obstructive pulmonary disease, coronary artery disease, prostate cancer, peripheral vascular disease, right above knee amputation, and adult failure to thrive. A review of Resident #13's Interdisciplinary Care Plan dated 05/16/11 did not document any hospice services. Review of Resident #13's medical record indicated he began receiving hospice services on 06/20/11. A review of a significant change Minimum Data Set (MDS) assessment completed on 06/25/11 indicated Resident #13 was receiving hospice services. In an interview with the Director Nursing Services (DNS) on 08/25/11 at 10:10 AM, she stated her expectation was to see hospice services on a resident's care plan if they were receiving hospice services. During an interview with the MDS Nurse on 08/25/11 at 11:30 AM, she stated when a resident	F 279		

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F 279	Continued From page 16 went on hospice services, a significant change MDS assessment was done and hospice services would be incorporated into the care plan. The MDS Nurse said a significant change MDS had been completed on Resident #13 on 06/25/11 and she did not know why the care plan had not been done to include hospice services. b. Resident #13 was admitted to the facility on 01/01/11 with diagnoses of chronic obstructive pulmonary disease, coronary artery disease, prostate cancer, peripheral vascular disease, right above knee amputation, and adult failure to thrive. A review of a significant change Minimum Data Set (MDS) assessment completed on 06/25/11 indicated Resident #13 had short term and long term memory problems and had moderate cognitive impairment for daily decision making. The assessment documented Resident #13 required extensive assistance with bed mobility, had lower extremity impairment on one side and was bed bound. A review of a Physical Therapy Discharge Summary on Resident #13 dated 02/10/11 documented Resident #13 had been discharged from therapy due to lack of progress onto a functional maintenance program and nursing caregiver carryover. A review of Resident #13's current care plan dated 05/16/11 did not address a functional maintenance program or document interventions for the prevention of complications from lower extremity impairment.	F 279		

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F 279	Continued From page 17 In an interview with Nurse #5 on 08/22/11 at 11:48 AM, she said Resident #13's left lower knee was contracted. An observation made with Nurse #5 on 08/22/11 at 11:56 AM revealed Resident #13 lying in bed on his right side with his left leg drawn up almost to his chest area and pillows placed between his right stump and behind his left knee area. On 08/24/11 at 9:40 AM in an interview with Nurse Aide #1, she stated Resident #13 needed verbal encouragement to straighten his left lower extremity as he tended to draw it up when lying in bed. NA #1 said she had to position Resident #13 using pillows between his legs as he tended to cross the right stump over the left leg and a pillow behind his left knee because he drew his legs up. NA #1 said she had not noticed any change in Resident #13's leg since he was admitted; just that he pulled them up more in bed. An observation made with NA #1 on 08/24/11 at 12:20 PM revealed Resident #13 was able to straighten his left leg approximately 50 % down with verbal cues but immediately drew it back up when he was repositioned on his side. NA #1 placed pillows back under his left knee and between his right stump and left leg. In an interview with Resident #13 on 08/25/11 at 9:10 AM, he stated he draws his legs up because it was comfortable for him. When asked to straighten his left leg out, he proceeded to straighten it approximately 50% down. In an interview with the Physical Therapy	F 279		

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F 279	Continued From page 18 Assistant (PTA) #1 on 08/25/11 at 9:40 AM, she said interventions had been put in place to prevent further contractures to Resident #13. They were to encourage frequent extension of his left leg, to provide active and passive range of motion exercises, and positioning with pillows in bed as he tended to draw his legs upward. In an interview with the Director Nursing Services (DNS) on 08/25/11 at 10:10 AM, she said she would expect to see a contracture addressed on a residents care plan with specific interventions such as active and passive range of motion exercises, positioning with pillows, or splinting if indicated. The DNS said the interventions should have been documented on Resident #13's care plan. In an interview with the MDS Nurse on 08/25/11 at 11:30 AM, she said she did not know why there were no interventions to prevent further contractures documented on Resident #13's care plan. 4. Resident #29 was admitted to the facility on 6/29/11 with cumulative diagnoses of muscle weakness and decreased mobility. Resident #29 had no history of falls. Resident #29's admission Minimum Data Set	F 279		

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F 279	Continued From page 19 (MDS) dated 7/6/11 indicated that Resident #29 was moderately impaired in cognition. Resident #29 needed limited one person assistance for transfers and extensive one person assistance for walking in the room and corridor. Resident #29 was not steady while moving from a seated to a standing position, while walking, while moving on and off the toilet, and while transferring between the bed and the chair or wheelchair. Resident #29 was only able to stabilize with human assistance while performing these tasks. Review of the Resident Progress Notes dated 7/27/11 at 11:15 PM indicated that staff had been called to Resident #29's room by Resident 29's room mate. Resident #29 had gone to sit on the commode and sat on the floor. Resident #29 was ambulated back to bed. The bed was in the lowest position and the call bell was in reach. The Responsible Party (RP) and the physician were notified of Resident #29's fall and that there were no apparent injuries. Review of the Medical Record showed no Care Plan (CP) for falls for Resident #29. In an interview on 8/24/11 at 12:40 PM with the Physical Therapy Manager (PTM), she stated that resident falls and the rehabilitation program were discussed in daily stand-up meetings at the facility. In an interview on 8/25/11 at 8:47 AM with Resident #29, it was indicated that an attempt to get to the bathroom was what preceeded the fall. Resident #29 denied memory of the actual fall.	F 279		

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F 279	Continued From page 20 In an interview on 8/25/11 at 11:34 AM with the traveling MDS nurse, she stated that the MDS department was responsible for the initial CP when a resident was admitted. If she was made aware of an incident happening after admission she would add a CP. She indicated that she had not been informed that Resident #29 had fallen. She stated that the most current CP's were kept in the charts. In an interview on 8/25/11 at 11:55 AM with the Director of Nursing Services (DNS), she indicated she had looked for, but could not locate, a falls CP for Resident #29. She stated that the DNS who no longer worked at the facility should have done a falls CP for Resident #29.	F 279	*This Plan of Correction is the center's credible allegation of 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 law.*	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to assess the dialysis related services for 1 of 1 sampled residents (Resident # 61) that received dialysis. Findings include: Resident # 61 was admitted on 12/29/10 and most recently readmitted on 06/15/11. Current	F 309	1. Individual in-service training was provided for Nurse #4 by the Director of Nursing on the facility's policy for care of dialysis patients, use of dialysis flow record, and the nurse's responsibility in awareness and implementation of the resident's care plan. The dialysis flow record was implemented for resident #61 on 9/1/2011. The dialysis flow record includes daily assessments of the dialysis access site, assessment of the resident hourly for 6 hours upon return from dialysis treatment, and documentation of type and location of dialysis access. 2. Residents receiving dialysis were identified through medical record review. Licensed nursing staff were in-serviced by the Director of Nursing regarding the facility's policy on care of dialysis residents, use of dialysis flow records, and the nurse's responsibility in awareness and implementation of the resident's care plan. Dialysis flow records were implemented for these identified residents on 9/1/2011. 3. The Director of Nursing will audit the dialysis flow records for residents receiving dialysis 3 x week x 2 weeks, weekly x 6 weeks, then monthly x 1 month to validate nurses are assessing	F 309 9/19/2011

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F 309	Continued From page 21 diagnoses included end stage renal disease (ESRD) requiring hemodialysis, hypertension, and congestive heart failure. The 04/28/11 Resident Weekly Skin Check Sheet indicated Resident # 61 had a dialysis access site in his right groin. The 05/21/11 Quarterly Minimum Data Set (MDS), indicated Resident # 61 was able to understand and be understood. The resident was assessed as severely cognitively impaired. There was no indication the resident rejected care. Special treatments included dialysis. The resident's care plan, last reviewed 06/10/11, indicated Resident # 26 was at risk for fluid volume excess related to ESRD. The goal to decrease edema and maintain a stable weight for 90 days was to be accomplished by auscultating lung sounds and documenting as indicated, assess and record edema, monitor laboratory values and give medications as ordered. On 06/15/11, a Readmission Nursing Assessment was completed that indicated Resident # 61 had a dialysis port in his right femoral artery. The resident had been hospitalized and received a new dialysis shunt secondary to an infection of the previous shunt. The shunt had been placed in the right groin. A nurse's note, dated 06/20/11 at 5:00 PM, indicated a call had been received from the hospital. The nurse documented she had received a call that indicated the dialysis shunt was replaced in the same groin as previously, but a different spot. The facility nurse documented	F 309	*This Plan of Correction is the center's credible allegation of 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 law.* the residents and completing the flow record as instructed. 4. Results of these dialysis flow record audits will be reported to the facility's Performance Improvement Committee monthly x 3 months for further review and recommendation.	

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F 309	Continued From page 22 she was instructed to keep the dressing to Resident # 61's groin in place. The June 2011 Treatment Sheet did not indicate the right groin dialysis site dressing had been checked on the dressing replaced. Review of the July 2011 Treatment Record indicated an entry to clean the dialysis site and apply a dry dressing as needed. There was no indication this had been done for the month of July. A nurse's note for 07/14/11 indicated the dressing to the right upper thigh was dry and intact with no bleeding noted. The August 2011 Physician's orders indicated Resident # 61's right groin dialysis site should be cleaned with wound cleanser and a dry dressing applied as needed due to soiling or accidental removal. The 08/07/11 Weight History indicated Resident # 61's weight had increased 12 pounds from 07/07/11 and 19 pounds since 04/07/11. Review of the nurse's notes for Resident # 61 from 08/05/11 through 08/25/11, revealed there had been one assessment of the resident's right groin dialysis site, no indication of edema, no indication his weight gain had been reported and no indication lung sounds had been auscultated as directed by the care plan. The nurse's note, dated 08/23/11 at 10:30 PM, indicated the dressing to the resident's right upper leg was dry and intact.	F 309		

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F 309	Continued From page 23 An interview was held with Nursing Assistant (NA) # 3 on 08/24/11 at 3:21 PM. She stated Resident # 61 received dialysis on Monday, Wednesday and Friday. The NA stated Resident # 61 left the facility around 10:00 AM and usually returned before 3:00 PM. An interview was held with the Director of Nursing Services (DNS) on 08/24/11 at 3:35 PM. The DNS stated coordination of services with dialysis was accomplished by phone call or by fax. She added facility nurses were expected to make sure residents that received dialysis took their medications, received the proper diet and also were expected to keep an eye on the dialysis shunt. The standard of practice, the DNS stated, would be for nurses to assess the shunt daily to make sure nothing is going on with the shunt. The expectation was for dialysis and care of the dialysis shunt to be care planned. An interview was held with Nurse # 4 on 08/25/11 at 10:52 PM. The nurse stated she worked with Resident # 61 5 times per week on the 7 to 3 shift. Nurse # 4 stated on return from dialysis Resident # 61 was assessed to make sure he was in no acute distress. The nurse stated the resident's dialysis shunt was in his left arm. Nurse # 4 stated she did not listen for the bruit or feel the thrill. The nurse added she did not assess the site for bleeding after dialysis. Nurse # 4 acknowledged she had not read the dialysis care plan for Resident # 61 and was unaware of what the care plan indicated she should do. The nurse reviewed the care plan and Resident # 61's treatment sheet and acknowledged she was unaware the resident's shunt was in his groin. She acknowledged she had not listened to his	F 309		

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F 309	Continued From page 24 lungs, had not assessed his shunt on return from dialysis and had not reported his weight gain to the physician or the Registered Dietician. During an interview with the DNS, she stated Nurse # 4 had worked with Resident # 61 for about 2 months. She added her expectation was for Nurse # 4 to know where the shunt was and for an assessment to be completed. The DNS stated she and the nurse had looked through the chart on 08/24/11 and could not find the location of the shunt. On review of the 06/15/11 Nursing Admission Assessment, the DON just shook her head yes when the assessment indicated the resident's shunt was in the right groin. She stated the treatment was ordered as needed, so therefore, if the resident had not needed the dressing changed, nothing would be documented on the treatment sheet. An interview was held with the resident on 08/25/11 at 12:05 PM. He stated his dialysis shunt was in his right groin. According to the resident, no one at the facility looked at his catheter. He stated the nurses at dialysis did that.	F 309	*This Plan of Correction is the center's credible allegation of 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 law.*	
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. This REQUIREMENT is not met as evidenced by:	F 312	1. Resident #16 was shaved on 8/24/11. 2. Nursing assistants and licensed nursing staff were in-serviced by the Director of Nursing on facility policy for removal of facial hair for male and female residents. 3. Department Managers will conduct facility rounds to identify residents with facial hair daily x 2 weeks, 3 x week x 6 weeks, then weekly x 4 weeks. Results of these rounds will be reported to the Director of Nursing who will then follow-up with appropriate staff to ensure facial hair is removed and disciplinary action taken as appropriate. 4. Results of these facility rounds and subsequent disciplinary actions will be reported to the facility's Performance Improvement Committee monthly x 3 months for further review and recommendation.	F 312 9/19/2011

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F 312	Continued From page 25 Based on observation, record review and staff interviews the facility failed to provide the removal of facial hair from 1 of 3 (resident #16) sampled residents whose activities of daily living were reviewed. Findings include: Resident #16 was admitted to the facility on 4/8/04 with cumulative diagnoses of dementia and cerebrovascular accident (CVA). Resident #16's quarterly Minimum Data Set (MDS) dated 7/20/11 indicated that Resident #16 had short and long term memory problems and was severely impaired in daily decision making. Resident #16 needed total assistance for all activities of daily living (ADL). Review of the facility Activities of Daily Living policy dated 4/28/10 indicated, "6. Assistance is provided to residents who need extensive or total assistance with maintenance of nutrition, grooming, and personal and oral hygiene." Review of Resident #16's Care Plan (CP) last updated 7/31/11 showed a problem with ADL deficits related to dementia and a history of CVA. The goal for the CP was that all ADL's would be met by the staff. Approaches included total care for all aspects of ADL's and to shave as needed. In an observation on 8/22/11 at 11:30 AM, Resident #16 was lying in a low bed. Resident #16 was unshaven and had an obvious growth of facial hair. In an observation on 8/23/11 at 9:30 AM, Resident #16 was lying in a low bed. Resident #16 was unshaven and had an obvious growth of	F 312		

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F 312	Continued From page 26 facial hair. In an observation on 8/23/11 at 12:25 PM, Resident #16 was lying in a low bed. Resident #16 was unshaven and had an obvious growth of facial hair. In an observation on 8/23/11 at 4:45 PM, Resident #16 was lying in a low bed. Resident #16 was unshaven and had an obvious growth of facial hair. In an observation on 8/24/11 at 9:10 AM, Resident #16 was lying in a low bed. Resident #16 was still unshaven. In an interview on 8/24/11 at 11:12 AM with the hospice aide, she indicated that she bathed, fed, and provided range of motion exercises for Resident #16 three times each week. She stated she shaved Resident #16 once each week. She indicated that on days she was not at the facility the Nursing Assistant (NA) assigned to the resident was responsible for care. She stated she believed the second shift NA was responsible for shaving Resident #16. In an observation on 8/24/11 at 11:55 AM, Resident #16 was lying in a low bed. Resident #16 had been shaved. In an interview on 8/24/11 at 3:30 PM with NA #1, she indicated that she worked with Resident #16. She stated she shaved Resident #16 once each week and when needed. She indicated she did not work on 8/23/11 but did work on 8/22/11. She did not know why Resident #16 had not been shaved.	F 312		

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F 312	Continued From page 27 In an interview on 8/25/11 at 9:30 AM with NA #2, she stated that residents should be shaved as often as necessary. If the residents needed to be shaved daily than the residents should be shaved daily. Residents should not be shaved only once each week. In an interview on 8/25/11 at 9:55 AM with nurse #5, she indicated that when a resident was placed on hospice, staff should continue to do everything they could for the resident as long as the resident would accept care. In an interview on 8/25/11 at 11:55 AM with the Director of Nursing Services (DNS), she stated that she expected bathing, dressing, transferring, feeding, grooming, shaving and assisting residents to the bathroom to be included in ADL care. She indicated that the 7-3 NA was responsible for shaving residents in A beds and the 3-11 NA was responsible for shaving residents in B beds. She expected the NA's to check daily to see if residents needed to be shaved. Shaving residents should not be done on a weekly basis. Even if a resident had a hospice aide she still expected her NA's to provide the needed care to the residents.	F 312	*This Plan of Correction is the center's credible allegation of 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 law.*	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	1. Resident #38 is currently being seen by physical therapy for contracture management, application and assessment of left knee splint, and development and training of Functional Maintenance Plan for the nursing department. 2. Residents receiving hospice care were identified through medical record review. The medical records of these identified residents were reviewed to ensure no outstanding treatment orders were still pending. None were identified with outstanding treatment orders. Therapy staff was in-serviced by the Area Rehab Manager on completion and follow through with therapy plan of care and communication with nursing when awaiting a physician's order for treatment. Licensed staff also in-serviced by the Director of Nursing on communication with the therapy department on the return of signed physician's orders for therapy treatment. Residents receiving therapy services will be discussed by the Interdisciplinary Team weekly during the Medicare meeting to validate services are provided as ordered and to ensure physician's orders are obtained timely and communicated to the therapy	F 318 9/19/2011

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F 318	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide a splinting device to maintain the range of motion for 1 of 3 (Resident #38) sampled residents who had contractures. Findings include: Resident #38 was admitted to the facility on 12/8/08 with cumulative diagnoses of cerebrovascular accident (CVA) and muscle weakness. Resident #38's quarterly Minimum Data Set (MDS) dated 7/30/11 indicated that Resident #38 was severely impaired in cognition. Resident #38 needed extensive one person assistance with bed mobility and toileting and was totally dependent on staff for dressing, personal hygiene and bathing. Resident #38 did not walk in the room or corridor during the assessment period. Review of the Weekly Physical Therapy Progress Notes dated 1/13/11-1/19/11 listed the justification for continued skilled services as improving balance and left knee extension in order to reach the maximal level of care for Resident #38. Review of the Weekly Physical Therapy Progress Notes dated 1/20/11-1/26/11 indicated that Resident #38's left leg was flexed in position in bed and that using a brace for that leg was a possibility. Review of the Weekly Physical Therapy Progress	F 318	*This Plan of Correction is the center's credible allegation of 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 law.* staff. The Rehab Manager will use this meeting forum to discuss pending physician orders for therapy treatment with the Interdisciplinary team for follow-up by the Director of Nursing. Payor changes will also be identified and discussed during this meeting forum. 3. The Rehab Manager will maintain a log of therapy treatment orders awaiting physician's signature. This log will be reviewed by the Interdisciplinary Team weekly on-going during the Medicare meeting to ensure timely follow-up and prevent delays in therapy treatment. 4. The Rehab Manager will provide copies of this log to the facility's Performance Improvement Committee monthly x 3 months for further review and recommendation.	

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Notes dated 1/27/11-2/2/11 indicated that Resident #38 complained of pain to the left knee and refused to straighten it. The treatment plan was to order an orthotic consultation to avoid flexion contracture of the left knee.

A review of the Rehabilitation Orders showed an orthotic consultation for Resident #38's left knee brace was signed by the physician and received by the facility on 2/7/11. The order had been noted by a licensed nurse on 2/10/11.

Review of the Weekly Physical Therapy Progress Notes dated 2/10/11-2/16/11 indicated Resident #38 had the start of a contracture to the left leg.

Review of the Weekly Physical Therapy Progress Notes dated 2/17/11-2/23/11 indicated the therapist was still awaiting an order for an orthotics consultation for a left knee brace for Resident #38.

Review of the Weekly Physical Therapy Progress Notes dated 2/24/11-3/2/11 indicated that the physical therapist was awaiting an order for an orthotic consultation to improve range of motion on the left knee and to improve the sitting balance for Resident #38.

Review of the Weekly Physical Therapy Progress Notes dated 3/10/11-3/16/11 indicated Resident #38 had a left knee contracture. Education was being provided to the Nursing Assistants (NA) and to Resident #38 to improve transfers and safety. The justifications for continued skilled services were to improve range of motion and to reach the highest level of care for Resident #38.

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F 318	Continued From page 30 A review of the Rehabilitation Orders showed a request for an orthotic consultation for Resident #38's left knee brace had been faxed to the physician a second time on 3/17/11. (The original signed order had been received by the facility on 2/7/11). Review of the Weekly Physical Therapy Progress Notes dated 3/17/11-3/23/11 indicated that range of motion to the left lower extremity was done for Resident #38 while in bed. Physical therapy was still awaiting an order for an orthotics consultation from Resident #38's physician so staff education could be completed. Review of the Weekly Physical Therapy Progress Notes dated 3/24/11-3/30/11 indicated that Resident #38 had a left knee contracture and would benefit from a knee extension brace. Staff education needed to be completed on how to put on and take off the left knee brace. Review of the Weekly Physical Therapy Progress Notes dated 4/7/11-4/13/11 indicated that Resident #38's left knee contracture continued and therapy was still awaiting an order for an orthotic consultation. A review of the Rehabilitation Orders for an orthotic consultation for Resident #38's left knee brace showed a third request had been faxed to the physician on 4/11/11, signed by the physician and returned to the facility. (The original signed order had been received by the facility on 2/7/11). Review of the Weekly Physical Therapy Progress Notes dated 4/14/11-4/20/11 indicated therapy was awaiting an orthotic consultation to improve	F 318		

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F 318	Continued From page 31 Resident #38's left knee extension. Review of the Weekly Physical Therapy Progress Notes dated 4/21/11-4/27/11 indicated therapy was awaiting an orthotics consultation to improve the left knee extension of Resident #38. A review of the Resident Progress Notes dated 5/3/11 showed that Resident #38 was admitted to hospice services that day. A review of the Rehabilitation Orders dated 5/4/11 showed that Resident #38's physician had signed a request sent by the physical therapist to discontinue PT as of 5/3/11 since the resident was now receiving hospice care. Review of the Physical Therapy Discharge Summary dated 6/2/11 indicated that Resident #38 had made some improvement with bed mobility but was unable to make progress with transfers due to a decline in medical status. A "ranger" brace for Resident #38's left leg had been received, but Resident #38 had been placed on hospice the day after it came in. The note indicated that physical therapy was unable to complete training with the staff on the use of the knee brace due to therapy being discontinued following hospice placement. Discharge recommendations included a Functional Maintenance Program (FMP)/Restorative Aide for positioning. A review of Resident #38's medical record did not show a FMP for physical therapy (PT). Review of Resident #38's Activities of Daily Living (ADL) Care Plan (CP) last updated 8/4/11,	F 318		

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showed a deficit in self care. The goal listed was that Resident #38 would receive any assistance needed in performing ADL activities. Under approaches, the provide adaptive/safety equipment box was unchecked and the blank space was filled in with the word none.

In an observation on 8/24/11 at 9:35 AM during wound care, Resident #38 did not have a brace on the contracted left leg. Resident #38 was unable to straighten out the leg even with the assistance of the licensed nurse.

In an interview on 8/24/11 at 9:50 AM with nurse #6, she stated that Resident #38 did not wear a brace on the left leg and had never had one that she was aware of.

In an interview on 8/24/11 at 11:12 AM with hospice aide #1, she indicated that she performed range of motion exercises for Resident #38 but had never seen Resident #38 wearing a leg brace.

In an observation on 8/24/11 at 12:35 PM Resident #38 was sitting up in the lobby in a specialized chair. There was no leg brace in place.

The physical therapist that had worked with Resident #38 was unavailable for interview.

In an interview on 8/24/11 at 12:40 PM with PTA #1 and the Physical Therapy Manager (PTM), PTA #1 indicated that Resident #38 had a left hamstring and left hip flexion contracture. She stated that once a resident was placed on hospice Physical Therapy (PT) no longer did

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F 318	Continued From page 33 anything. She indicated that the physical therapist did not have the opportunity to place the brace on Resident #38 and assess its use. The PTM stated she had faxed the hospice office the appropriate information regarding the leg brace and that Resident #38 had been discharged from PT. She was unable to provide a copy of the fax or any note stating the information had been sent. The PTM stated that the PT department's responsibility ended once the information was faxed to hospice and that they did not do any kind of follow-up to be sure the information had been received by hospice. The PTA #1 stated she had spoken to a hospice nurse who came to the facility but was unable to produce any notes regarding the conversation. The PTM stated that the facility did not have a restorative aide program. In an interview on 8/24/11 at 2:05 PM with the hospice RN, she stated that she explained to the PTA #1 and the PTM that since Resident #38 had received the leg brace prior to being placed on hospice services that the PT department could teach the staff how to use the brace and continue its use for Resident #38. She was unable to provide any notes regarding the conversation. She stated she did not remember receiving a fax in the hospice office from the PTM. She indicated it was her understanding that the PT department would train the nursing staff to use the brace that Resident #38 had. She stated she did not remember ever seeing Resident #38 wearing a brace on the left leg. In an interview on 8/24/11 at 3:25 PM with PTA #1, she indicated that the brace for Resident #38's left leg had been requested on 4/21/11 and	F 318		

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F 318	Continued From page 34 delivered on 4/28/11. She stated that the brace was probably being stored out in the storage barn and that she would go and bring it in to the facility. In an interview on 8/25/11 at 9:15 AM with the Social Worker (SW), she stated that normally residents were not placed on hospice services until therapy was finished. In an interview on 8/25/11 at 9:30 AM with the Restorative Nursing Aide, she indicated she weighed residents, passed the snack cart and applied splints and braces. She stated that she did not only work as the restorative aide. Some days she had an assignment instead. On the days she had an assignment; the other aides provided restorative nursing to the residents. She indicated that when a resident was discharged from therapy the physical therapist would in-service the NA's on how to apply the splints/braces correctly. She stated that the therapy department had not in-serviced the NA's on any braces for Resident #38 in recent months. In an interview on 8/25/11 at 11:00 AM with the Director of Nursing Services (DNS), she indicated that the facility had a restorative aide that would walk people and apply splints. In an interview on 8/25/11 at 9:55 AM with nurse #5, she stated that when a resident was placed on hospice the staff should continue to do everything they could to provide proper care. In an interview on 8/25/11 at 11:55 AM with the DNS, she stated it was her expectation that when a resident was placed on hospice the staff	F 318		

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F 318	Continued From page 35 provided the same care as before the resident was placed on hospice. She indicated that the therapy department should have done a Functional Maintenance Plan (FMP) and provided training to the staff on how to use the brace that had been ordered for Resident #38. She stated that the facility was ultimately responsible for providing the care that Resident #38 required.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to provide large portions of protein for 2 of 6 sampled residents (Residents # 26 and # 61) whose nutritional status was reviewed. Findings include: 1. Resident # 26 was admitted on 07/31/08 and most recently readmitted on 06/17/11. Current diagnoses included acute cholecystitis, biliary drainage tube placement, coronary artery disease, diabetes, congestive heart failure,	F 325	*This Plan of Correction is the center's credible allegation of 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 law.* 1. Diet orders for large portions of meat and eggs at all meals for residents # 26 and #61 were communicated to the dietary department and tray cards updated to reflect these orders. 2. Diet orders and tray cards for current residents were compared and tray cards updated as appropriate. Licensed nursing staff was in-serviced by the Director of Nursing on communication of diet orders to the dietary department with the use of the Dietary Communication Form.	F 325 9/19/2011

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F 325	Continued From page 36 hypertension and anemia. The resident's weight was recorded on the 06/17/11 Nursing Assessment as 189 pounds. The assessment indicated Resident # 26 had no nausea or vomiting. He was assessed as alert and oriented, not confused and appropriate. Resident # 26 was documented as being independent with eating. The resident's care plan, dated 06/17/11, did not address the potential for weight loss or actual weight loss. The care plan did not address the resident's increased need for protein. The Medical Nutrition Therapy Assessment, dated 06/20/11, indicated Resident # 26 received a low concentrated sweet diet, regular texture and thin liquids. Average food intake was recorded as 100%. The assessment indicated Resident # 26 had a left above the knee amputation surgical site. Dining skills were recorded as independent. The Registered Dietician noted under COMMENTS, that Resident # 26 consumed adequate intake to meet nutritional needs. She did indicate increased protein needs were needed to promote healing of his surgical site. The Registered Dietician (RD) documented the resident's diet provided 2100 calories, 90 grams of protein. The goal was to prevent significant weight change and maintain adequate hydration. Monitoring and evaluation would include food and beverage intake, weight change, skin. The RD indicated she would proceed to care plan related to the resident receiving a therapeutic diet. Recommendations included adding large portions of meat and eggs. On 06/20/11, the physician approved the RD's	F 325	*This Plan of Correction is the center's credible allegation of 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 law.* 3. The Director of Nursing will monitor communication of diet orders to the dietary department weekly by comparing the dietitian's recommendations to the Dietary Communication Forms to validate diet orders were communicated to the dietary department. The Director of Nursing will note on the dietitian's recommendations that the dietary department was notified of the diet order weekly as validation occurs. 4. The Director of Nursing will provide copies of the dietitian's recommendations with her noted validations of communication to the facility's Performance Improvement Committee monthly x 3 months for further review and recommendation.	

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F 325	Continued From page 37 recommendations. An Admission Minimum Data Set (MDS), dated 06/24/11, indicated Resident # 26 was able to understand and be understood. Resident # 26 was assessed as moderately cognitively impaired. The Nutritional Care Area Assessment Summary, dated 06/30/11, indicated the resident had no nutritional problems, therefore, nutrition would not be care planned. On 07/04/11, a physician's order indicated the resident was sent to the hospital for evaluation of right side pain. Laboratory work performed during hospitalization, on 07/04/11, indicated an albumin of 2.7 (normal range 3.4 to 5.0). An observation was made on 08/23/11 at 12:16 PM. Resident # 26's lunch tray card indicated he received standard portions. The resident had eaten 100% of his meal. An observation was made on 8/23/11 at 5:06 PM. The resident's tray card indicated standard portions. The resident was served a sloppy joe. The meat on his sandwich matched what other resident's sitting at his table received. No large portion of meat was observed. An observation was made of breakfast on 08/24/11 at 8:00 AM. The resident received 1 boiled egg and 3 slices of bacon as protein. Resident # 26's tray card indicated he received a standard portion. An interview was held with Resident # 26 on	F 325		

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F 325	Continued From page 38 08/24/11 at 8:35 AM. He stated he received the same amount of meat and eggs as everyone else received. An interview was held with Nursing Assistant (NA) # 3 on 08/24/11 at 3:21 PM. The NA stated information regarding resident's diets was found on the tray card with each meal. She added if a resident received double meats/eggs, it would be listed on the tray card. The NA stated Resident # 26 received a regular diet with no double meats. An interview was held with the Director of Nursing Services (DNS) on 08/24/11 at 3:35 PM. The DNS stated information regarding residents could be found and was available to NA's in the FMP (Functional Maintenance Program) Book. The book included diet orders. If the information was not in the book, the DNS stated the NA was expected to ask the nurse. The DON stated she was unsure if Resident # 26 received a special diet. A FMP sheet was not found in the book for Resident # 26. The form was requested, but not received. An interview was held with the DNS on 08/24/11 at 4:37 PM. She stated when a dietary order was received, a form was filled out with the diet order and sent to the dietary department. The DNS stated the extra protein for Resident # 26 was needed for his low albumin and wound healing. An interview was held with the Dietary Manager (DM), Rochelle, on 08/24/11 at 4:45 PM. She stated Resident # 26 received double meats and eggs at breakfast only. An interview was held with the Registered	F 325		

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F 325	Continued From page 39 Dietician (RD) on 08/25/11 at 9:21 AM. The RD stated the recommendation was made for Resident # 26 to receive extra meat and extra eggs related to a healing surgical site. The RD added the intent of her recommendation and the 06/20/11 physician's order was for all meals and not just breakfast. The RD stated 3 slices of bacon and 1 boiled egg did not qualify as large meat/eggs. An interview was held with the DM on 08/25/11 at 10:10 AM. The DM stated she had spoken with the RD and had been informed Resident # 26 should have received large meat/egg portions at all meals. The DM stated the resident should have received 3 pieces of bacon and 2 boiled eggs for his breakfast on 08/24/11. An interview was held with Nurse # 4 on 08/2/11 at 10:46 AM. The nurse stated she was not aware Resident # 26 should have received double meats and eggs. Information about diets was found in the nutrition section of each resident's charts. NA's would get the information about large portions from the meal tray card. Nurse # 4 added with the information not on the tray card and the nurse unaware, the NA would have no way of knowing Resident # 26 should have received large portions of meat and eggs. 2. Resident # 61 was admitted on 12/29/10 and most recently readmitted on 06/15/11. Current diagnoses included end stage renal disease requiring hemodialysis, depression, paraplegia, hypertension and congestive heart failure. The 05/21/11 Quarterly Minimum Data Set	F 325		

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F 325	Continued From page 40 (MDS), indicated Resident # 61 was able to understand and be understood. The resident was assessed as severely cognitively impaired. Resident # 61 was coded as requiring extensive assistance with bed mobility, transfer, toilet use and personal hygiene and coded as requiring supervision with eating. The last Medical Nutrition Therapy Review for Resident # 61, dated 05/25/11, indicated the resident had increased nutrient needs for calories and protein related to increased physiologic demand as evidenced by a diagnosis of end stage renal disease (ESRD) requiring hemodialysis. The Registered Dietician (RD) documented the resident's albumin was 3.5, which was less than desirable for dialysis but likely adequate to meet nutrition needs. The recommendation was made for Resident # 61 to receive large portions of meat and eggs at all meals to increase protein consumption. On 06/09/11, the physician approved the RD's recommendation to provide large portions of meat and eggs at all meals. The resident's care plan, last reviewed 06/10/11, indicated Resident # 61's had an alteration in nutrition related to ESRD. Goals were indicated as hydration maintained, laboratory values within a normal range, adhere to diet and tolerate mechanically altered diet. Approaches included encouraging intake of food and fluids, notifying the RD and physician of significant weight change, abnormal labs and skin breakdown, monitor weights, intake and nutritional parameters with each nutritional review, and provide a high protein diet, no added salt, limited	F 325		

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F 325	Continued From page 41 concentrated sweet diet as ordered. Laboratory results, dated 07/20/11, indicated Resident # 61's albumin was 3.2 (normal range 3.4 to 5.0). The August 2011 physician orders indicated Resident # 61 received a no added salt, limited concentrated sweets, large portions of meat and eggs at all meals with no bananas, oranges, tomatoes or orange juice. An observation was made of on 08/23/11 at 5:28 PM. Resident # 61 received a half peanut butter and jelly sandwich, tater tots, baked beans, sloppy joe and a fruit cup. The resident received no more meat than other resident's at his dining table. An observation was made of breakfast on 08/24/11 at 8:00 AM. For protein Resident # 61 received 2 slices of bacon and a portion of scrambled eggs equaled to the other residents at the table. No extra portion of eggs was seen. An interview was held with Nursing Assistant (NA) # 3 on 08/24/11 at 3:21 PM. She stated Resident # 61 was always ready to eat and had complained of hunger on return from the dialysis center. The NA added the resident was on a fluid restriction, but was unsure if he was on a special diet. An interview was held with the Director of Nursing Services (DNS) on 08/24/11 at 3:35 PM. The DNS stated information regarding residents was available to NA's in the FMP (Functional Maintenance Program) Book. The book included	F 325		

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F 325	Continued From page 42 special diets. If the information was not in the book, the NA was expected to go to the nurse. The DON stated she was unsure if Resident # 61 received a special diet. The facility nurses are expected to make sure any resident that received dialysis took medications and received the proper diet. An interview was held with the Registered Dietician (RD) on 08/25/11 at 9:14 AM. The RD stated her concerns for any resident that received dialysis was to ensure adequate intake of calories and protein. After review of Resident # 61's chart, the RD stated he received large portions of meats and eggs for added protein needs. An interview was held with the Dietary Manager (DM) on 08/25/11 at 10:13 AM. She stated Resident # 61 received large portions of meat and eggs at all meals. She stated the resident should have gotten an extra scoop of eggs and 2 pieces of bacon. The DM stated that if the there was no difference in Resident # 61's portion and other resident's portion of eggs, then he did not receive extra eggs.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	*This Plan of Correction is the center's credible allegation of 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 law.* 1. Resident # 52 Dilantin level was drawn 7/19/2011 and was 10.5 ug/mL, which is within therapeutic range. Resident #52 has not experienced seizure activity since the 7/19/11 Dilantin check. 2. Residents receiving Dilantin were identified through medical record review. Medical records were reviewed by the Director of Nursing to ensure Dilantin levels had been drawn as ordered and no seizure activity had occurred during the past 6 months requiring additional Dilantin levels be drawn. Licensed nursing staff was in-serviced by the Director of Nursing on notification of the physician following seizure activity and the need to request additional Dilantin levels be drawn when seizure activity occurs.	F 329 9/19/2011

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F 329	Continued From page 43 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain immediate Dilantin levels for 1 of 3 sampled residents (Resident #52) receiving seizure disorder medications who experienced seizure activity. The facility also failed to obtain timely follow-up Dilantin levels for Resident #52 when the Dilantin dosage was adjusted and when a Dilantin lab value was obtained which was not within normal limits. Findings include: Resident #52 was admitted to the facility on 08/20/09 and readmitted on 12/31/09. The resident's documented diagnoses included seizure disorder, psychosis, and paranoia. Resident #52 was readmitted to the facility on 12/31/09 with orders for Phenobarbital 100 milligrams (mg) daily (QD) and Dilantin ER (extended release) 200 mg QD.	F 329	*This Plan of Correction is the center's credible allegation of 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 law.* 3. The Director of Nursing will review the 24 hour report book daily during clinical rounds to identify residents experiencing seizure activity. These identified residents will be reviewed to validate the physician was notified of the seizure activity and Dilantin levels were ordered and obtained when seizure activity occurred. The Director of Nursing will maintain a log of residents experiencing seizure activity, notification of the physician, and Dilantin draws and results. 4. The Director of Nursing will provide copies of this log to the facility's Performance Improvement Committee monthly x 3 months for further review and recommendation.	

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F 329	Continued From page 44 Lab results documented on 05/06/10 Resident #52's Dilantin level was 13.2 micrograms per milliliter (ug/mL), with the normal range being 10 - 20 ug/mL and the therapeutic range being 6 - 14 ug/mL. Review of resident progress notes revealed on 09/07/10 Resident #52 was uncharacteristically agitated/irritated when asked to move away from a door. On 09/13/10 resident expressed a desire to go to the hospital and was documented as having "slight lethargy". Analysis of urine collected on 10/15/10 revealed the resident did not have an urinary tract infection. On 10/20/10 Resident #52's physician requested Dilantin and Phenobarbital levels be obtained (specimen not collected until 11/10/10). On 10/28/10 and 11/04/10 the resident was found on the floor. Record review revealed there were no November 2010 Dilantin/Phenobarbital lab results in Resident #52's active or thinned record material. The facility was able to obtain a copy from a computerized system which documented on 11/12/10 the resident's Dilantin level was high at 20.8 ug/mL, with the normal range being 10 - 20 ug/mL and the therapeutic range being 6 - 14 ug/mL. However, there was not a copy of these lab results initialed by facility staff as being received or initialed by the physician as being reviewed, and there was no documentation in resident progress notes that lab results outside of normal limits were received by the facility or relayed to Resident #52's primary physician. Review of resident progress notes revealed Resident #52 was found on the floor in the lobby	F 329		

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F 329	Continued From page 45 on 11/24/10. A 02/01/11 5:30 PM resident progress note documented Resident #52 experienced seizure activity and was unable to speak for approximately one minute in the dining room. A 02/02/11 11:00 AM resident progress note documented, "_____ (name of physician) in to have medical visit of resident (Resident #52). A 02/02/11 physician progress note documented, "No recent seizure activity. FU (follow-up) Phenobarbital and Dilantin levels next visit." A 02/22/11 7:15 PM resident progress note documented Resident #52 began shaking and experienced seizure activity in the dining room which lasted approximately four to five minutes. 03/15/11 and 04/06/11 physician progress notes for Resident #52 did not address the resident's February 2011 seizure activity or obtaining Phenobarbital or Dilantin levels. Resident #52's Dilantin level was not checked again until May 2011. Lab results documented on 05/12/11 the resident's Dilantin level was 19.6 ug/mL, with the normal range being 10 - 20 ug/mL and the therapeutic range being 6 - 14 ug/mL. A 05/16/11 physician's order reduced Resident #52's daily dose of Dilantin from 200 mg to 150 mg. A 06/04/11 12:30 PM resident progress note documented Resident #52 was eating lunch in	F 329		

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F 329	Continued From page 46 the dining room when seizure activity, which lasted a little less than two minutes, began. A pharmacy recommendation dated 06/09/11 requested that a follow-up Dilantin level be drawn since Resident #52's Dilantin dosage was "recently reduced". The facility did not draw another Dilantin level for Resident #52 until 07/19/11. 07/20/11 lab results documented Resident #52's Dilantin level was 10.5 ug/mL, with the normal range being 10 - 20 ug/mL and the therapeutic range being 6 - 14 ug/mL. At 11:25 AM on 08/24/11 the medical records clerk stated resident #52 was only supposed to have Dilantin levels drawn every six months. At 4:55 PM on 08/24/11 Nurse #3 stated she had worked with Resident #52 since February 2011, and it was very difficult to get the resident to take her medications. This nurse reported it was very important to get the resident to take her PM medications because this was when the resident received her anti-seizure medications. She commented it seemed there was a pattern when the resident refused her PM meds, she experienced seizure activity the next day. Since February 2011, Nurse #3 reported Resident #52 refused PM meds about three or four times for her. At 11:23 AM on 08/25/11 Nurse #4 stated she had worked with Resident #52 since June 2011, and since that time the resident refused to take her medications approximately eight times.	F 329		

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F 329	Continued From page 47 At 12:15 PM on 08/25/11 the Director of Nursing (DON) stated it was the pharmacist's responsibility to remind the facility when to draw labs on anti-seizure medications. However, she reported labs on anti-seizure medications such as Dilantin and Phenobarbital should be drawn immediately following active seizure activity, shortly after a change in dosage, and shortly after an abnormal value was obtained. The DON stated a copy of lab results should be in resident charts to reveal documentation (in the form of a date and staff initials or name) that the lab was acknowledged/received by the facility and the resident's physician was notified of the result. The DON was unable to explain why there was not a copy of Resident #52's 11/12/10 lab results in her active or thinned record material. According to the DON, the facility had no book or report on which to document resident concerns which needed to be discussed with physicians during their visits. She commented apparently Resident #52's physician was not informed about the resident's seizure activity during a 02/02/11 on-site visit. The DON stated as soon as the pharmacist made a recommendation to draw a follow-up lab, the physician should be contacted immediately to make sure an order was obtained and the lab was drawn at once. She reported a wait of over a month from the date of the pharmacy recommendation to draw a follow-up lab on anti-seizure medication was not acceptable. The DON explained usually staff took pharmacy recommendations to the physician offices to get them signed, and if a response was not obtained in a couple of weeks, staff placed a call to the physician offices. However, she remarked on important recommendations, the	F 329		

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F 329	Continued From page 48 staff could call physician offices to get an immediate response and possible order. The DON reported she was unaware Resident #52 was experiencing seizure activity. She commented Resident #52 should have had a follow-up lab drawn in November 2010 following an elevated Dilantin level on 11/12/10 and should have had a Dilantin level drawn in February 2011 when the resident experienced seizures on 02/01/11 and 02/22/11.	F 329	*This Plan of Correction is the center's credible allegation of 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 law.*	
F 371 SS=E	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 and staff interview the facility failed to maintain hot foods at 135 degrees or higher on the steam table, failed to sanitize a sink used for thawing raw meats, and failed to use clean and undamaged kitchenware in the preparation and serving of food. The facility also failed to place a thermometer in the refrigerator holding resident foods and failed to make sure all food items in this refrigerator were labeled and dated. Findings include: 1. At 11:38 AM on 08/24/11 food temperatures	F 371	1. Unable to correct temperatures obtained during surveyor observation on 8/24/11. Sink used for thawing of raw hamburger was cleaned and sanitized on 8/24/11. Robot Coupe was cleaned on 8/24/11 prior to use. Identified soiled dishware was pulled and cleaned prior to use. Identified damaged dishware was removed from use and replacements ordered by the dietary manager. Thermometer placed in resident refrigerator located in the dining room and temperature log initiated on 8/26/11. 2. Dietary staff were provided in-service training by the dietary manager on checking and maintaining acceptable temperatures for foods on the steam table, facility policy for thawing raw meat, facility policy for cleaning and sanitizing sinks, inspection of dishware for cleanliness and damage, maintaining temperature log for resident refrigerator located in the dining room, and removal of undated and unlabeled items in the refrigerator. 3. The Administrator will complete kitchen rounds 3 x week x 2 weeks, 2 x week x 2 weeks, then weekly x 2 months to check food temperature logs, cleanliness of sinks and equipment,	F 371 9/19/2011

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	345375	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF SCOTLAND NECK	920 JR HIGH SCHOOL RD SCOTLAND NECK, NC 27874

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F 371	Continued From page 49 were taken before operation of the trayline began, using a calibrated thermometer. The chicken livers registered 140 degrees Fahrenheit, the collards registered 165 degrees, the beans registered 175 degrees, the puree chicken livers registered 140 degrees, the puree collards registered 145 degrees, the puree beans registered 150 degrees, the rice (alternate starch) registered 140 degrees, the hamburger patties (alternate meat) registered 140 degrees, and the baked chicken (alternate meat) registered 140 degrees. The trayline began operation at 12:03 PM on 08/24/11. At 12:37 PM on 08/24/11, while the trayline was still operating, a calibrated thermometer was used to recheck the temperature of foods on the steam table. The chicken livers registered 110 degrees Fahrenheit, the collards registered 120 degrees, the bean registered 120 degrees, the puree chicken livers registered 122 degrees, the puree collards registered 110 degrees, the puree beans registered 110 degrees, and the hamburger patties (alternate meat) registered 108 degrees. At this time, the Dietary Manager (DM) stated the steam table was relatively new, and the dietary staff had never had problems with it not working. The DM verified that all the wells in the steam table were set on the highest heat setting. However, she reported she thought the problem might be that there was very little water in the steam table wells. She commented no hot water came close to making contact with the bottom of the tray pans containing the foods. At 3:18 PM the DM stated she thought the	F 371	*This Plan of Correction is the center's credible allegation of 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 law.* identify soiled or damaged dishware, undated or unlabeled food in refrigerator, and compliance with temperature log on refrigerator. The dietary manager will do kitchen rounds daily x 2 weeks, 3 x week x 2 weeks, 2 x week x 4 weeks, then weekly x 1 month to validate accurate food temperatures on steam table, observe for dirty equipment or sinks, identify soiled or damaged dishware, validate documentation of refrigerator temperatures on log, and identification of undated or unlabeled items in refrigerators. 4. Results of these audits will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

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F 371	Continued From page 50 regulation required that hot foods be kept at 145 degrees Fahrenheit or higher during the operation of the trayline. However, she reported she preferred that hot foods be kept at 160 degrees Fahrenheit on the steam table while resident trays were being prepared. The DM commented the steam table was only a couple of years old so she did not think there was a problem with the way it functioned. She reported that the dietary staff took the temperature of foods on the steam table one time each meal, just before the operation of the trayline began. At 3:30 PM on 08/24/11 a dietary employee stated she thought the regulation required hot foods on the steam table to register at least 140 degrees Fahrenheit during the entire operation of the trayline. She reported food temperatures were supposed to be taken just before the trayline began operation and again later when the trays were being prepared to go out in the third cart to leave the kitchen. 2. At 9:36 AM on 08/24/11 the cook placed two rolls of raw hamburger under running water in the two-compartment sink to help thaw it out so it could be used to form hamburger patties (one of the alternate meats for the lunch meal) and to be added to the pinto beans in the ranch style beans recipe. One roll was still in the plastic wrapper. The other roll was removed from the plastic wrapper, and partially enclosed in aluminum foil. The foil did not completely enclose the bottom of the roll. At 10:16 AM on 08/24/11 the thawing hamburger was removed from the two-compartment sink, but there was loose hamburger still in the bottom of	F 371		

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F 371	Continued From page 51 the sink and around the sink drain. At 12:42 PM on 08/24/11 the sink where the raw hamburger was thawed had not been cleaned or sanitized. At 3:18 PM on 08/24/11 the Dietary Manager (DM) stated the hamburger was thawed in the correct sink in the two-compartment system, one sink reserved for meats and the other reserved for the preparation of fruits and vegetables. However, she reported she preferred a sink used in the preparation of raw meats to be sanitized immediately after the preparation tasks were completed, using a quaternary sanitizing solution, so that other dietary employees would not try to prepare foods in the same contaminated sink by accident. At 3:30 PM a dietary employee stated a sanitizing solution was supposed to be used to wash out sinks immediately after food was prepared in them. She commented this helped lessen the chance of employees contaminating other foods, their hands, or kitchenware by mistake. 3. At 9:06 AM on 08/24/11 there was a yellow substance along the interior bottom edge of the Robot Coupe in the kitchen. At 9:47 AM on 08/24/11 the cook cut up an onion and began to place it in the chamber of the Robot Coupe. The cook was stopped by the surveyor. The cook reported she did not see the yellow substance left in the chamber. She commented this was egg which was prepared in the Robot Coupe earlier that same morning.	F 371		

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F 371	Continued From page 52 During an inspection of kitchenware, beginning at 11:28 AM on 08/24/11, 7 of 18 sectional plates had dried yellow food particles in them, 8 of 18 had dried brown food particles in them, 1 of 18 had dried tan food particles in it, and 6 of 18 had dividing walls which were chipped. At this time, the Dietary Manager (DM) instructed the dietary employee in charge of operating the dish machine that the sectional plates needed to be soaked in order to help remove food particles before the plates were run through the dish machine. At 3:18 PM on 08/24/11 the DM stated sectional plates were supposed to be clean before being placed in storage. The DM reported staff were supposed to pull damaged kitchenware, such as sectional plates with chipped dividing walls, out of stock and and leave it for her to inspect, count, and reorder. At 3:30 PM a dietary employee stated the facility did not use kitchenware which was damaged, such as chipped or cracked plates, because it made it more likely that bacteria could grow and make residents sick. 4. An observation was made of the refrigerator where resident food was kept on 08/24/11 at 2:18 PM. In the refrigerator was a slice of chocolate cake with no name and date, a half styrofoam glass of an orange liquid with no date and name and a bottle of water in the freezer section with no date and name. There was no thermometer in the refrigerator to determine the temperature. The Director of Nursing Services (DNS) stated in	F 371		

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F 371	Continued From page 53 an interview on 08/24/11 at 2:18 PM that there should have been a thermometer in the refrigerator and without one, the temperature could not be checked. She was not aware of any log where the temperatures had been checked. The DNS stated without food dated and labeled there was no way of knowing how long the food had been in the refrigerator, so therefore, there was a risk of food spoilage. An interview was held with the Administrator on 08/24/11 at 2:44 PM. The Administrator stated the responsibility for maintaining correct temperatures for the resident refrigerator belonged to the Dietary Manager (DM). He added temperatures for the refrigerator should be taken three times a day. The expectation was for the temperature to be recorded on a log. The Administrator added temperature logs were kept for up to a year. The danger of not having a thermometer in the refrigerator was the temperature would be unknown and food could get warmer than it should be which could lead to illness. All food in the refrigerator should be dated and labelled. The Administrator stated labeling was important so dietary staff would know how long the food had been in the refrigerator to prevent food from spoiling. An interview was held with the DM on 08/25/11 at 10:05 AM. She stated the dietary department was responsible for making sure the temperature in the resident's food refrigerator was safe. She stated the dietary department was also responsible to keep the refrigerator clean and to make sure food was labelled and dated. She stated she had noticed about a month ago the thermometer was missing and she knew she	F 371		

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F 371	Continued From page 54 should have put one back. The DM stated replacing the refrigerator thermometer had slipped her mind. The DM stated prior to the missing thermometer, she had not kept a temperature log: She added employees were expected to date and label items that go into the refrigerator..	F 371	*This Plan of Correction is the center's credible allegation of 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 law.*	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview, pharmacist interview, and record review the facility was not notified that 1 of 3 sampled residents (Resident #52) receiving seizure disorder medications had an abnormal Dilantin level drawn and experienced seizure activity so that a follow-up Dilantin level could be obtained. Findings include: Resident #52 was admitted to the facility on 08/20/09 and readmitted on 12/31/09. The resident's documented diagnoses included seizure disorder, psychosis, and paranoia. Resident #52 was readmitted to the facility on	F 428	1. Unable to correct for resident #52 as missing pharmacist documentation and requests occurred in November 2010, February 2011, and May 2011. Resident #52 most recent Dilantin level was obtained on 7/19/2011 and was within therapeutic range at 10.5 ug/mL. 2. Residents receiving anti-seizure medications were identified through medical record review. Medical records were reviewed by the Director of Nursing to validate current orders for anti-seizure drug levels were present, current lab results were present in the medical record, and no seizure activity had occurred within the past 6 months. Consultant Pharmacist received in-service training by the Clinical Manager with Pharmerica on therapeutic anti-seizure drug levels, special occasions when anti-seizure drug levels should be checked more frequently, and the need to review the medical record to identify seizure activity for residents receiving anti-seizure drugs. The in-service also reviewing the facility's 24 hour report books, standards of care minutes, and interviewing staff to identify when residents have experienced seizure activity between consultant pharmacist visits. These methods will be used in addition to the medical record review.	F 428 9/19/2011

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F 428	Continued From page 55 12/31/09 with an order for Dilantin ER (extended release) 200 mg daily (QD). Record review revealed there were no November 2010 Dilantin lab results in Resident #52's active or thinned record material. The facility was able to obtain a copy from a computerized system which documented on 11/12/10 the resident's Dilantin level was high at 20.8 micrograms per milliliter (ug/mL), with the normal range being 10 - 20 ug/mL and the therapeutic range being 6 - 14 ug/mL. However, there was not a copy of the lab results initialed by facility staff as being received or initialed by the physician as being reviewed, and there was no documentation in resident progress notes that lab results outside of normal limits were received by the facility or relayed to Resident #52's primary physician. There was no follow-up Dilantin lab drawn following the abnormal value obtained on 11/12/10. The pharmacist's 11/18/10, 12/16/10, and 01/27/11 medication regimen reviews did not document that Resident #52 had an abnormal Dilantin level obtained on 11/12/10. A 02/01/11 5:30 PM resident progress note documented Resident #52 experienced seizure activity and was unable to speak for approximately one minute in the dining room. The pharmacist's 02/22/11 medication regimen review documented a Dilantin level was obtained for Resident #52 in November 2010, but did not document that the result exceeded normal limits. In addition, there was no documentation that Resident #52 experienced seizure activity (on 02/01/11) in the pharmacist's review.	F 428	*This Plan of Correction is the center's credible allegation of 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 law.* 3. The Clinical Manager for Pharmerica will review the consultant pharmacist's monthly report monthly x 3 months to ensure lab tests are requested for anti-seizure medications as appropriate. 4. Results of these audits will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

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F 428	Continued From page 56 A 02/22/11 7:15 PM resident progress note documented Resident #52 began shaking and experienced seizure activity in the dining room which lasted approximately four to five minutes. The pharmacist's 03/18/11 and 04/21/11 medication regimen reviews did not document an abnormal Dilantin level was obtained for Resident #52 nor that the resident experienced active seizures in February 2011. Resident #52's Dilantin level was not checked again until May 2011. Lab results documented on 05/12/11 the resident's Dilantin level was 19.6 ug/mL, with the normal range being 10 - 20 ug/mL and the therapeutic range being 6 - 14 ug/mL. A 05/16/11 physician's order reduced Resident #52's daily dose of Dilantin from 200 mg to 150 mg. At 11:25 AM on 08/24/11 the medical records clerk stated resident #52 was only supposed to have Dilantin levels drawn every six months. At 10:32 AM on 08/25/11, during a phone interview with the facility's consultant pharmacist, she stated Dilantin lab values should be drawn every six months. However, she reported, if the physician had not already done so, she would request a follow-up Dilantin level shortly after obtaining a level outside of the normal range and "at once" for a resident experiencing active seizures. According to the pharmacist, symptoms of an elevated Dilantin level were lethargy, sedation, dizziness, and eyeballs moving side to	F 428		

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F 428	Continued From page 57 side. (Resident #52 expressed a desire to go to the hospital, and nursing documented the resident presented with slight lethargy on 09/13/10. Resident #52 fell on 10/28/10, 11/4/10, and 11/24/10). The pharmacist stated she did not document on Resident #52's abnormal Dilantin level in her November 2010 through May 2011 medication regimen reviews. She commented maybe the November 2010 lab results (including a Dilantin level) were not present in Resident #52's chart, she thought the resident's physician was addressing the elevated Dilantin lab, or she was waiting to recommend a follow-up Dilantin level because the November 2010 value was only slightly high. She acknowledged that she did not address active seizure activity for Resident #52 in her February 2011 medication regimen review. The pharmacist reported she must not have seen the 02/01/11 resident progress note documenting active seizures for Resident #52, or she would have requested an immediate Dilantin level in her 02/22/11 medication regimen review. At 12:15 PM on 08/25/11 the Director of Nursing (DON) stated it was the pharmacist's responsibility to remind the facility when to draw labs on anti-seizure medications. She reported labs on anti-seizure medications such as Dilantin should be drawn immediately following active seizure activity, shortly after a change in dosage, and shortly after an abnormal value was obtained. The DON stated a copy of lab results should be in resident charts to reveal documentation (in the form of a date and staff initials or name) that the lab was acknowledged/received by the facility and the resident's physician was notified of the result. The DON was unable to explain why there was	F 428		

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F 428	Continued From page 58 not a copy of Resident #52's 11/12/10 lab results in her active or thinned record material. According to the DON, she was unaware Resident #52 was experiencing seizure activity. She commented Resident #52 should have had a follow-up lab drawn in November 2010 following an elevated Dilantin level on 11/12/10 and should have had a Dilantin level drawn in February 2011 when the resident experienced seizures on 02/01/11 and 02/22/11.	F 428	*This Plan of Correction is the center's credible allegation of 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 law.*	
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 (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.	F 441	1. Individual in-service training provided by the Director of Nursing for nursing assistant #3 on hand washing and facility's policy for the handling of clean and soiled linen/clothes. Nursing assistant #3 identified as working with resident # 54 on 8/24/11. 2. In-service training provided for nursing assistants and licensed nurses by the Director of Nursing Services regarding hand washing and the facility's policy on handling of clean and dirty linen/clothes. 3. The Director of Nursing will observe 5 nursing assistants providing incontinent care or bathing weekly x 8 weeks, then monthly x 1 month to validate compliance with facility's policy for hand washing and handling of clean and dirty linen/clothes. 4. The Director of Nursing will provide copies of observations to the facility's Performance Improvement Committee monthly x 3 months for further review and recommendation.	F 441 9/19/2011

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GUARDIAN CARE OF SCOTLAND NECK	920 JR HIGH SCHOOL RD SCOTLAND NECK, NC 27874

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F 441	Continued From page 59 (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 observations, staff interviews and record review the facility failed to practice standard infection control policies by failing to change gloves and wash hands between handling soiled and clean linens/clothes for 1 of 2 sampled residents (Resident # 54) whose care was observed. Findings include: According to the facility's policy, titled, Hand Hygiene/Handwashing, dated 10/31/09, handwashing is the single most important procedure for preventing the spread of infection. The policy indicated handwashing was to be performed after toileting, assisting others with toileting or after personal grooming. Furthermore, the policy indicated handwashing was to be performed after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves were worn. Review of an in -service, presented by the facility Staff Development Coordinator (SDC) on 05/12/11, indicated that Nursing Assistant (NA) # 3 had attended. Information included in the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 60 in-service included handwashing. An observation was made on 8/24/11 at 2:37 PM. NA # 3 provided incontinent care to Resident # 54. The NA wiped front to back removing feces from the resident. Without changing her gloves or washing her hands, she applied moisture barrier and a clean incontinent brief. The NA stated the reason she did not change gloves between a handling providing incontinent care and handling the clean incontinent brief was there was no obvious soiling on her gloves. The NA stated she had been taught to change gloves and wash her hands when the gloves were visibly soiled. She stated bacteria could not be seen so therefore there was a chance bacteria could be spread without the gloves being visibly soiled. An interview was held with the Director of Nursing Services (DNS) on 08/24/11 at 3:35 PM. The DNS stated until 2 weeks ago she had been the facility's SDC, a position she held for 18 months. The DNS stated NA's were taught to change gloves if they became visibly soiled, torn, and between resident contact. She added the staff had been taught to change gloves between handling dirty and clean items. The expectation was for staff to use soap and water to cleanse the resident and then remove the soiled gloves , wash their hands and don clean gloves prior to handling clean briefs. The DNS stated the importance of changing gloves was to prevent contamination and spreading of infection. She added potentially gloves could carry Escherichia coli even if the gloves had not been visibly soiled.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF SCOTLAND NECK	920 JR HIGH SCHOOL RD SCOTLAND NECK, NC 27874

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K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 09/14/2011 the dry sprinkler system did not have a low and high pressure switch that monitored the air pressure on the dry side of the system. 42 CFR 483.70 (a)	K 056	*This Plan of Correction is the center's credible allegation of 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 law.* 1. It is the practice of the facility to keep the sprinkler system in compliance. It was noted during the life safety survey that our sprinkler did not have a High-Low switch at the compressor on the dry sprinkler system to monitor pressure. 2. We will have an outside contractor come in to install the High-Low switch to the sprinkler system. The switch will be tested. 3. The Maintenance Director will check and monitor the switch for proper operation weekly and by our service contractor performing the quarterly inspections. 4. Findings will be discussed during our monthly safety committee meeting. RECEIVED OCT 6 2011	10/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DeShae Morse	Executive Director	9/30/11

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.