STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3316 FAITH CHURCH RD INDIAN TRAIL, NC 28079

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and facility record review the facility failed to promote a dignified dining experience by providing plastic cutlery to 1 of 1 sampled resident. (Resident #76) The findings are: Resident #76 was admitted in 2011 with a diagnosis of Depression and Arthritis. An admission minimum data set (MDS) dated 9/8/11 noted Resident #76 was assessed as having cognitive impairment and required extensive assistance with eating. A quarterly MDS dated 12/1/11 noted she was assessed as cognitively intact and required set up assistance with eating. A nursing progress note dated 12/1/11 documented that Resident #76 voiced a comment of concern. She was placed on precautions which included every fifteen minute visual checks; she was also assessed by the physician. The administrator and director of nursing (DON) were notified and a physician's order was obtained for a psychological evaluation. A physician progress note dated 12/1/11 revealed that the medical director (MD) interviewed	F 241	Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. RECEIVED JAN 23 2012 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin. Director — (X6) DATE: 1/19/12

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.

Original Signature 1-13-12 mh

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F 241	Continued From page 1 Resident #76. The MD indicated that he did not think Resident #76's comment was a worrisome situation and recommended the psychologist re-evaluate and staff continue to monitor the Resident. A physician progress note dated 12/2/11 documented that Resident #76 made no further concerning comments and that she had no memory of her previous comment. Psychological consultations dated 12/5/11, 12/12/11 and 12/15/11 noted that Resident #76 had no further concerns that would warrant the use of plastic cutlery. The care plan dated 12/14/11 indicated that Resident #76 was at risk for not having her needs met and/or compromised dignity related to her decreased mobility. Approaches included that staff allow and encourage her to make choices and include Resident #76 in establishing her daily routines. The care plan did not include the use of plastic cutlery for this Resident. On 12/19/11 from 12:15 PM to 12:45 PM a continuous meal observation was conducted. Resident #76 was noted eating in the dining room with a plastic spoon in her right hand. Using the plastic spoon, she attempted to cut a sweet potato. The spoon fell into her lap and pieces of the sweet potato fell onto her skirt, the clothing protector and the floor. Resident #76 then picked up a plastic fork and stuck the fork into the sweet potato. As she brought the fork toward her mouth pieces of the sweet potato fell onto the table as well as her clothing protector. She then attempted to eat her soup with the plastic fork. At 12:33 PM she pulled her clothing protector off and placed it on the tray. She consumed approximately 25% of	F 241	F241 Resident #76 started receiving regular silverware on 12/21/11. A 100 percent audit was completed of all residents on 12/22/11 by the DON to assess any other residents utilizing plastic ware. Any areas identified were corrected as appropriate for each individual resident needs. All nursing, dietary staff and feeding assistants were inserviced, completed on 1/16/12 by the Staff Development Coordinator on dignity and the proper use of plastic ware, when to discontinue this practice, and how to use a change of order form for staff to communicate with dietary when these areas require change.	

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F 241	Continued From page 2 her meal. At 12:45 PM Resident #76 was noted to have sweet potato and turnip greens on her skirt, clothing protector and the floor. Her tray card documented she was to receive plastic ware. During a meal observation on 12/20/11 Resident #76 entered the dining room at 12:17 PM and her lunch meal tray was noted with plastic cutlery. Licensed nurse #2 (LN #2) stated at 12:37 PM that Resident #76 received plastic cutlery due to a comment of concern made by the Resident. On 12/21/11 at 8:09 AM Resident #76 was observed with silverware. The plastic cutlery was removed from her meal tray and tray card. Resident #76 was observed eating eggs with silverware without dropping the silverware or her food. On 12/21/11 at 12:28 PM the certified dietary manager (CDM) reported that Resident #76 received plastic cutlery for more than two weeks. The CDM stated that he received communication from nursing that plastic cutlery was to be placed on the Resident's meal tray because of a concerning comment made by the Resident. He also stated that on 12/20/11, nursing notified him to discontinue the plastic cutlery and to give Resident #76 silverware. On 12/21/11 at 3:22 PM Resident #76 was interviewed regarding the use of the plastic cutlery and stated that it was not comfortable to eat with and that she often dropped it. She also stated that she would rather eat with the silverware but did not know why she was given the plastic ware.	F 241	Director of Nursing or Weekend Manager will audit all residents to include Resident # 76 with silverware precautions weekly for four weeks then monthly for three months utilizing the Temporary Dietary Change Form. The Administrator will review the audit results weekly for four weeks then monthly for three months to assure any areas identified have been corrected. The audit results will be reviewed monthly by the Quality Improvement Committee to assess trending, additional monitoring needs, and continued compliance in this area. Completion date 1/25/12	

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F 241	Continued From page 3 An interview with the DON on 12/22/11 at 12:58 PM revealed that Resident #76 threatened to kill herself earlier that month. As part of facility practice the Resident was given plastic ware during dining. The DON stated that the Resident had no recollection of her suicidal statement on the next day and did not require the plastic utensils after the second day. An interview with Resident #76 on 12/22/11 at 2:21 PM revealed that the plastic ware made her feel terrible and like a slouch. The plastic utensils made it hard to eat and caused her food to fall on her clothing. She further stated that if she had a choice she would prefer to have silverware.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to attempt alternatives to drug therapy for behavioral symptoms for one (1) of four (4) sampled residents who received psychoactive medications (Resident #151). The findings are: Resident #151 was admitted 1/21/11 to the facility with diagnoses which included Dementia. The	F 250	F 250 The Care Guide for Resident # 151 was updated on 1/11/12 by Social Services Director to include past personal information to be used by staff as possible behavioral interventions. A 100 percent audit was completed on 1/13/12 by Social Services Department for all residents to include those receiving psychoactive medications and all Care Guides were updated to include past personal information to be used by staff for possible behavioral interventions	

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F 250	Continued From page 4 most recent quarterly Minimum Data Set (MDS) dated 10/12/11 assessed Resident #151 with severely impaired cognition and physical and verbal behavioral symptoms directed toward others. Review of Resident # 151's care plan, updated on 11/9/11, revealed a concern of behavior characterized by agitation and combativeness which was difficult to redirect. Interventions listed were: no invasion of personal space; administration of medication; documentation of episodes; give Resident a task; and monitor and document behaviors of hitting, kicking at staff, and spitting out medications. Review of Resident # 151's record revealed the following: · 10/07/11: Nursing note documented Resident arguing with staff and unable to be redirected. · 10/18/11: Nursing note documented Resident spat out medication. · 10/19/11: Nursing note documented Resident was difficult to redirect and confrontational with staff. · 11/03/11: Nursing note documented Resident combative with care in shower. · 11/07/11: Nursing note documented Resident was agitated and yelling. · 11/10/11: Nursing note documented Resident grabbed another resident ' s arm. · 11/11/11: Nursing note documented Resident verbally threatened another resident and staff member. · 11/17/11: Nursing note documented Resident attempted to hit staff. · 11/18/11: Nursing note documented Resident attempted to hit staff.	F 250	Social Work and Activity Department staff was inserviced on 1/11/11 by the Administrator on including personal information on Care Guides to assist in behavioral interventions from direct care staff. All Nurses and Nursing Assistants were inserviced and completed by 1/16/12 by the Staff Development Coordinator on where the past personal information is located in the revised Care Guides for use in assisting in behavioral interventions when appropriate. Social Service staff will review all Care Guides to insure all residents to include Resident #151 and those receiving psychoactive medications have accurate, timely personal information related to behavioral interventions on their Care Guides utilizing a Care Guide SS Information Tracking Form weekly for four weeks then monthly for three months. The Administrator will review the audit results weekly for four weeks then monthly for three months to assure any identified areas were corrected as appropriate.	

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F 250	Continued From page 5 · 11/21/11: Mental Health visit note which stated staff reported stable behavior with no recommendation for change of the current order for Ativan (for anxiety) 1mg every 12 hours as needed. · 11/21/11: Nursing note documented Resident yelled and cursed at staff. · 11/27/11: Nursing note documented Resident hitting and cursing at staff. · 11/28/11: Nursing note documented Resident bit a staff member. Ativan (for anxiety) administered by injection after physician notification. · 11/29/11: Resident attempted to hit staff and threw objects. Physician ordered Abilify 5 mg at bedtime for paranoia. Review of the November 2011 Medication Administration Record (MAR) revealed Ativan 1 mg by mouth documented as administered five times (11/21, 11/23, 11/26, and twice on 11/28) for agitation. Further review of Resident #151's record revealed the following: · 12/06/11: Nursing note documented Resident became angry at another resident's noise and pushed the resident in a wheelchair into a door. There was no injury to either resident. Physician ' s orders dated 12/6/11 directed a scheduled dose of Ativan 1 mg daily at 9:00AM and increase frequency of as needed Ativan 1 mg from every 12 hours to every 8 hours. · 12/08/11: Nursing note documented Resident tore out wires of a speaker. Ativan administered by injection after physician notification. · 12/12/11: Physician's orders for an increase in frequency of Ativan to twice daily with Depakote	F 250	The audit results will be reviewed monthly by the Quality Improvement Committee to assess trending, additional monitoring needs, and continued compliance in this area. Completion Date 1/25/12	

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F 250	Continued From page 6 syrup (for behavior) 125 mg daily for dementia with increased agitation. · 12/14/11: Nursing note documented Resident agitated and refused care. · 12/16/11: Nursing note documented Ativan 1 mg by injection administered for combative behavior. · 12/19/11: Nursing note documented Resident disrobed and unable to be redirected.. · 12/20/11: Physician's order for Depakote increase to Depakote sprinkles 250mg at 6:00AM and 12:00 PM and 500mg at 6:00PM. Review of the December 2011 Medication Administration (MAR) revealed Ativan documented as administered nine times (on 12/3, 12/5, twice on 12/6, 12/7, 12/8, 12/9, 12/11 and 12/19) in addition to the scheduled doses. Observation on 12/21/11 from 7:55 AM to 9:30AM revealed Resident #151 paced in the hallway without difficulty. Staff redirected her when she attempted to order other residents to tasks. Observation on 12/21/11 at 2:53 PM revealed Resident #151 pacing on the unit and asking to leave the unit. At 3:10 PM, Resident #151 gathered the covers from her bed and shouted to staff and residents. Resident #151 continued yelling and began spitting when Nursing Assistant (NA) #4 attempted to orient to place and situation. Resident #151 resumed pacing the dementia unit. Interview with NA #1 on 12/22/11 at 9:41 AM revealed she had cared for Resident #151 for two months. NA #1 explained she received no specific information or direction related to Resident #151's behavior but tried different	F 250		

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F 250	Continued From page 7 approaches to see what worked. NA #1 revealed she received information from Resident #151's family members and other Nursing Assistants. NA #1 reported Resident #151 frequently became angry and required close monitoring. She did not know why Resident #151 became angry and tried to figure out the reason. NA #1 reported she was not aware or a part of team discussions related to attempts to attempts to determine possible triggers of Resident #151's agitation. Interview with NA #2 on 12/22/11 at 9:57 AM revealed she had cared for Resident #151 for 2 weeks. NA #2 explained she listened to Resident #151 and tried to understand her speech which became garbled when upset. NA # 2 explained Resident # 151 did not always know which words to use. NA #2 reported her approach to Resident #151 was by trying different things out to see if it worked. She did not know why Resident #151 became angry and tried to figure out the reason. NA #2 reported she was not aware or a part of team discussions related to attempts to determine possible triggers of Resident #151's agitation. Interview with Licensed Nurse (LN) #1 on 12/22/11 at 10:22 AM revealed staff shared information related to Resident #151's behavior orally in report and was not aware of any staff meetings related to Resident #151 for behavior management. LN #1 reported Resident #151 received medication for anxiety. LN #1 revealed she was not aware of any other behavioral interventions for Resident #151 or team meetings to discuss possible triggers of the Resident's agitation..	F 250		

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F 250	Continued From page 8 Interview with the facility's Social Worker (SW) on 12/22/11 at 11:03 AM revealed she referred Resident #151 to mental health on 1/24/11 after admission for adjustment difficulties. The SW explained she had no role related to Resident #151's behavior management but was aware Resident #151's behavior required medication for behaviors. Interview with Director of Nursing (DON) on 12/22/11 at 11:50 AM revealed that although there no specific team meetings with direct care staff related to Resident #151's behavior, she expected staff to share information informally.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to place eye ointment inside the lower eyelids during medication pass for one (1) of four (4) residents observed receiving eye medications. (Resident # 4). The findings are: A review of a facility policy that was undated and titled "Administration of Eye Ointment" stated "Pull down lower eyelid with the index or middle finger creating a pouch. Instruct the resident to look up. Steady hand by placing against resident's forehead and squeeze a small amount	F 281	F281 Resident # 4 was assessed by a RN on 12/22/11 for any adverse reaction to observed application of eye ointment with no negative outcome. The licensed nurse who administered the eye ointment to resident #4 was immediately inserviced on 12/21/11 by the Staff Development Coordinator on the appropriate procedure for administration of eye ointment. All licensed nurses were inserviced and completed on 12/22/11 by the Staff Development Coordinator on the appropriate procedure for administration of eye ointment.	

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F 281	Continued From page 9 (1/8 inch) of medication inside of lower eyelid close to the outer corner of the eye." Resident # 4 was admitted to the facility with diagnoses including methicillin-resistant Staphylococcus aureus (MRSA), dementia, and macular degeneration. During an observation of medication administration on 12/21/11 at 4:50 PM, Licensed Nurse (LN) #5 picked up a container of Tobramycin/Dexamethasone eye ointment and squeezed the ointment onto the index finger of her gloved hand and wiped the ointment across the lower eyelid of Resident # 4's right (R) eye. LN # 5 then squeezed the ointment onto the second finger of her gloved hand and wiped the ointment across the lower eyelid of Resident #4's left (L) eye. Both of Resident # 4's lower eye lids were bright red in color. During an interview on 12/22/11 at 4:55 PM with LN #5 she stated she was not exactly sure how she should administer the eye ointment. During an interview on 12/22/11 at 7:50 AM with a Nurse Practitioner (NP) she stated Resident #4 had blepheritis which was a chronic eye condition. She further stated "we have had so many eye infections with her" and she's getting the eye ointment to manage her chronic eye problems. She explained she expected nursing staff to put the ointment directly into the conjunctival sac inside the lower eye lids. She stated nursing staff should not wipe the ointment across the lower eyelids but should put it directly into the eyelid for it to be effective.	F 281	The Director of Nursing and/or Nursing Supervisor will audit administration of eye ointments to include Resident #4 utilizing a Eye Ointment Administration Tracking form to assure correct administration technique is completed weekly for four weeks then monthly for three months. Any areas identified will correct to include additional training to licensed nurses if appropriate. The Administrator will review the audit results weekly for four weeks then monthly for three months to assure any identified areas were corrected as appropriate. The audit results will be reviewed monthly by the Quality Improvement Committee to assess trending, additional monitoring needs, and continued compliance in this area. Completion date 1/25/12	

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F 281	Continued From page 10 During an interview on 12/22/11 at 9:40 AM with a Regional Clinical Pharmacy Manager/Consulting Pharmacist she stated nursing staff should administer eye ointments inside the lower eyelids unless a physician specifically ordered for the application to be different. She explained the resident should close their eye to allow the medication to cover the inside surfaces of the eyelid and eye for the ointment to be effective. During an interview on 12/22/11 at 2:45 PM the Director of Nurses (DON) she stated it was her expectation nursing staff should place eye ointment into the lower eye lid according to their facility policy. She further stated the method of applying eye ointment to the outside of the eye lid was not the approved practice in the facility.	F 281		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff and vendor interviews the facility failed to remove expired tube feeding products and canned foods from 1 of 2 dry food storage areas.	F 371	F 371 All expired items were removed and discarded on 12/19/11 by the Dietary Manager. An audit of the kitchen and storage areas was completed on 12/20/11 by Dietary Manager to assure that no other items had reached their expiration dates. Any items found were discarded immediately and facility replaced products as appropriate.	

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F 371	Continued From page 11 The findings are: A facility dietary policy, revised September 2006, documented in part that the dietary manager or designated qualified employee was responsible for receiving, checking and storing items delivered to the facility. Food and stock items were to be dated and rotated. An observation on 12/19/11 at 11:00 AM of the emergency food storage room revealed the following items were stored past the date of expiration. · Two, 68 ounce containers of peach sauce with a manufacturers stamped expiration date of 8/16/08 and receipt date of 11/3/10 · One, 68 ounce container of peach sauce with a manufacturer stamped expiration date of 9/16/08 and a facility receipt date of 11/3/10 · Six, 68 ounce containers of pineapple sauce with a manufacturer stamped expiration date of 8/18/09 and facility receipt date of 11/9/10 · Five, 68 ounce containers of pear sauce with a manufacturer stamped expiration date of 10/9/09 and a facility receipt date of 11/9/10 · Six, 68 ounce containers of fruit cocktail with manufacturer stamped expiration date of 1/11/10 and facility receipt date of 11/9/10 · Five, 68 ounce containers of peach sauce with a manufacturer stamped expiration date of 1/12/10 and a facility receipt date of 11/9/10 · Six, ten ounce cans of vanilla pudding with a manufacturer stamped expiration date of 11/9/10 · Three cases of pureed carrots, two cases of pureed green beans and one case of pureed peas; 14.75 ounce cans, each case had a manufacturer expiration date of 11/9/11	F 371	All Dietary staff and Supply staff were inserviced and completed on 1/12/11 by Administrator regarding rotation of stock to assure products are used before expiration dates and when to remove products from stock due to expiration dates. The tube feeding supplies were relocated to the medical storage area on 12/20/11 by Dietary Manager to assure they will be monitored more closely as well. The Dietary Manager and/or dietary aide will review areas including refrigerators, freezers, and dry storage to assure no items have expired utilizing a Date Tracking Form weekly for four weeks then monthly for three months. Any areas identified will be discarded and replenished as appropriate. The Administrator will review the audit results weekly for four weeks then monthly for three months to assure any identified areas were corrected as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 · Two cases of 2 cal HN (enteral feeding product) with an expiration date of 10/1/2011 · One case of Jevity 1.2 calories (enteral feeding product) with an expiration date of 11/1/11 An interview with the certified dietary manager (CDM) on 12/19/11 at 11:00 AM revealed that all canned foods are dated when received. He also stated that the tube feeding and pudding products were expired and that they should have been discarded. The CDM confirmed that he was responsible for the monitoring and removal of out dated items from the emergency storage area. The CDM stated that all items with expired dates should be thrown away and that he would verify with the manufacturer what the stamped date on the food products represented. He did not provide an explanation as to why the fruit sauces were received after the manuafturer's date stamp of expiration. On 12/21/11 at 12:05 PM the CDM reported that he had contacted the manufacturer but did not receive verification of the significance of the stamped date on the food products. He also stated that he in-serviced his staff to discard any canned products that were on the shelf past the date stamped on the can. The CDM confirmed that the standard shelf life of canned products was one year unless otherwise indicated by the stamped date. A telephone interview on 12/22/11 at 12:23 PM with the manufacturer revealed that the manufacterer's date stamped represented the expiration date and that consumers were encouraged to use products by this date and not	F 371	The audit results will be reviewed monthly by the Quality Improvement Committee to assess trending, additional monitoring needs, and continued compliance in this area. Completion Date 1/25/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	12/22/2011

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F 371	Continued From page 13 after this date to ensure food quality.	F 371		

Care Guide SS information tracking form

Monthly Audit

Care Guides updated Y/N	100 hall	200 hall	300 Hall	400 Hall	500 Hall	600 Hall	700 Hall
	Y	Y	Y	Y	Y	Y	Y

Comments: 1-12-12: All Care Guides updated to include Past Personal Information.

New Admission Audit

Resident Name	Room #	Admit Date	Care Guide updated Y/N	Date Updated	Staff Initials	Notes:
Helen Rushing	400A	1-11-12	Y	1-16-12	EJ	
Harry Harris	709P	1-17-12	Y	1-19-12	EJ	
Joann McHarry	721B	1-17-12	Y	1-18-12	EJ	
Martha Huffman	708P	1-17-12	Y	1-19-12	EJ	
Robert Phillips	704P	1-17-12	Y	1-18-12	EJ	
Ronald Cook	724B	1-16-12	Y	1-18-12	EJ	

Notes for QI meeting: _____ 1/19/12

Care Guide SS information tracking form

Monthly Audit

Care Guides updated Y/N	100 hall	200 hall	300 Hall	400 Hall	500 Hall	600 Hall	700 Hall
	Y	Y	Y	Y	Y	Y	Y

Comments: 1-19-12: All care guides updated to include Past Personal Information

New Admission Audit

Resident Name	Room #	Admit Date	Care Guide updated Y/N	Date Updated	Staff Initials	Notes:
Jacqueline Atwell	~~706P~~ 706P	1-19-12				
Mildred Kartikis	720B	1-19-12				

Notes for QI meeting: _____ 1/19/12

Care Guide SS information tracking form

Monthly Audit

Care Guides updated Y/N	100 hall	200 hall	300 Hall	400 Hall	500 Hall	600 Hall	700 Hall
	Y	Y	Y	Y	Y	Y	Y

Comments: 1-12-12: All Care Guides updated to include Past Personal Information.

New Admission Audit

Resident Name	Room #	Admit Date	Care Guide updated Y/N	Date Updated	Staff Initials	Notes:
Helen Rushing	400 A	1-11-12				

Notes for QI meeting:

1/13/12

Date tracking form

Week starting: 1/11/12

Document expired goods and disposal in comments section

Date	Walk in Frig/Freezer Y/N	Kitchen Refrigerator Y/N	Floor Refrigerator Y/N	Kitchen Pantry Y/N	Kitchen 3-day Y/N	Floor Nourish Rooms Y/N	Staff Initials	Comments
1/11/12	NO	NO	NO	NO	NO	NO		open Milk containers
1/12/12	NO	NO	NO	~~NO~~ YES	NO	NO		removed out dated items
1/13/12	NO	NO	NO	NO	NO	NO		
1/14/12								
1/15/12								
1/16/12	NO	NO	NO	NO	NO	NO		lots of open milk containers
1/19/12	None	None	None	None	None	None		

Notes for QI meeting: 1/13/12

1/19/12

Ointment Administration

Date	Resident	Location	Time Observed	Correct Technique Y/N	Immediate retraining Y/N	Observing Nurse Int.	Comments:
1/11/12	Pauline Mellon	102A	9A	Y			
1/12/12	Lillie Underoth	201B	1P	Y			
1/20/12	Beatrice Knight	202A	10A	Y			

Notes for QI meeting:_____ 1/20/12

Ointment Administration

Date	Resident	Location	Time Observed	Correct Technique Y/N	Immediate retraining Y/N	Observing Nurse Int.	Comments:
11/2/12	Pauline Medlin	102A	9A	Y		[signature]	
11/12/12	Ella Wentworth	201B	1P	Y		[signature]	

Notes for QI meeting:_____ 11/13/12

Temporary Dietary Changes Form

Resident Name	Room #	Item(s) Changes	Date Changed	Reason Changed	Staff Initials	Date Returned	Staff Initials

Notes for QI meeting: No orders wk 1/9/12 - 1/16/12 1/16/12
No orders - 1/17/12 - 1/20/12 1/20/12