STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING ______ B. WING ______	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYSTONE HEALTH & REHABILITATION	80 BROWNSBERGER CIRCLE FLETCHER, NC 28732

(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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record reviews the facility staff failed to follow up on resident grievances for missing property for one (1) of three (3) residents. (Resident #13) The findings are: A review of a facility document titled "Grievance" dated 05/01/09 revealed in part "the grievance form is available to family, resident's and advocates at the reception desk, nurse's station and Department Head office. The form is completed by resident, family, or advocate and returned to a Department Head or Administrator. The grievance form is brought to the facility's morning stand up meeting and logged into the concern log by Administrator or designee." Resident #13 was admitted with diagnoses including hypertension and depression. The most recent annual Minimum Data Set (MDS) dated 01/25/12 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. During an interview on 02/28/12 at 8:40 AM with Resident #13 she stated two or three weeks ago	F 166	*BeyStone Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is March 30, 2012. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, our scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.* ***F-166*** The facility will continue to provide prompt efforts to resolve grievances the resident may have. Resident #13's glasses were replaced by family member; resident was interviewed by the Social Services Director to ascertain if she had any other concerns or missing items. None were identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D Smith — TITLE: Administrator — (X6) DATE: 3/26/12

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.

RECEIVED APR 0 2 2012 BY: MH
RECEIVED FEB 2 6 2012 BY: MH

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F 166	Continued From page 1 she put her eyeglasses on her over bed table at bedtime and they were gone the next morning. She further stated she reported her eyeglasses were missing to everybody who cared for her but they did not talk to her about what they were going to do about it and her husband bought her new eyeglasses. A review of facility grievance logs dated 2011 and 2012 revealed there was no documentation on the concern log and there was no grievance form for Resident #13's missing eyeglasses. During an interview on 03/01/12 at 9:56 AM the Director of Social Services explained grievance forms were kept in a file drawer at the nurse's station and staff were expected to complete a grievance form and give it to the social worker or Director of Nursing (DON) when a resident had missing property. She stated residents usually told staff when their personal property was missing. She explained if a resident reported missing property at night, staff filled out the grievance form and it was reviewed at the morning meeting and investigated. She further explained if a resident reported missing property during the day shift, staff filled out the grievance form for the resident and they turned it in to the DON or Social Worker for investigation. She stated she was aware that Resident #13's glasses were missing about a month ago but was not sure who followed up or talked with the resident about her concerns about her missing eyeglasses.. She stated we should have documented our investigation to make sure the resident's concerns and grievance was fully addressed.	F 166	All remaining residents and/or family were interviewed regarding any items of concern or missing items. All items identified were resolved per facility grievance policy/procedure. All staff members were inserviced regarding facility grievance policy/procedure. The Social Services Director/designee will interview all alert and oriented residents weekly/x 1 month to ensure concerns are resolved per facility policy. The Social Service Director will document on the "Weekly Interview Social Service QA" form. Compliance will be monitored with any grievance forms being brought to the QA Committee for the next two months to assure resolution and to assure standard is met. Then all grievances will be reviewed at each QA meeting permanently thereafter. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through interviews, audits, and through the facility's Quality Assurance Program.	
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

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

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F 241 SS=D	Continued From page 2 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 interviews, staff interviews and record reviews the facility staff failed to change a resident's soiled clothing and provide nail care to promote dignity in one (1) of eighteen (18) sampled residents (Resident #23). The facility staff also failed to promote dignity by sitting and facing the resident at eye level during feeding for one (1) of three (3) residents. (Resident #2). The findings are: 1. During an observation on 02/28/12 at 8:45 AM the door to Resident #23's room was open and she was sitting on the side of her bed. She was wearing a red shirt with food stains on the front of her shirt and her fingernails on each hand were long and broken and had brown debris under the nails. During an interview on 02/28/12 at 8:50 AM Resident #23 stated she had just finished her breakfast but she spilled some of it on her shirt and was waiting for her shower. She also stated it was embarrassing for her to wear clothing with food spilled on it and it made her feel bad. During an observation on 02/28/12 at 10:55 AM	F 241	*F-241* The facility will continue to 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. Resident #23 was changed into a clean shirt at time of notification and provided nail care. Resident #2 is fed by staff at eye level. All residents were assessed for soiled clothing, stained clothing, and nail care. All staff were in-serviced on dignity issues which include nail care, changing of clothing and the dining environment. A QA monitoring tool, "Manager Daily Round Sheet" will be utilized by nursing staff to ensure residents are in clean clothing and skin/nail care is done timely/appropriately. The D.O.N./designee will conduct random audits to include skin care, nail care, changing of clothing, and the dining experience, daily/x2 weeks, then weekly thereafter to ensure compliance by using the "Random Audit of Manager Rounding" form. All issues identified will be corrected immediately.	

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F 241	Continued From page 3 the door to Resident #23's room was open and she was sitting on the side of her bed with the same red shirt on with food stains on the front of her shirt. During an interview on 02/28/12 at 11:00 AM Resident #23 stated she was still waiting for her shower and she expected for it to be done today. During an observation on 02/28/12 at 1:50 PM the door to Resident #23's room was open and she was sitting on the side of her bed with the same red shirt on with food stains on the front and was reading a book. During an observation on 02/29/12 at 8:36 AM the door to Resident #23's room was open and she was sitting on the side of her bed with the same red shirt on with food stains on the front. During an interview on 02/29/12 at 8:37 AM Resident #23 explained she did not get her shower yesterday and she slept in the same clothes she wore yesterday. She stated she did not know why she didn't get a shower and stated "I expect for them to take care of me and I expect for them to change my clothes every day. That's why I'm in here because I can't take care of myself 24 hours a day." She further stated she needed staff help with dressing and "I can't do much of nothing for myself and I expect to have clean clothing on each day." During an observation on 02/29/12 at 9:05 AM Resident #23 was sitting on the side of her bed and held out her hands. The nails on both hands were long and broken and had brown debris under each of the nails.	F 241	Compliance will be monitored by the monthly QA committee for the next 3 months or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through random observation/record review and through the facility's Quality Assurance program.	

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F 241	Continued From page 4 During an interview on 02/29/12 at 9:08 AM Resident #23 stated "It bothers me for my nails to look like this" and stated she did not routinely get nail care unless she requested it. During an observation on 02/29/12 at 11:33 AM the door to Resident #23's room was open and she was sitting on the side of the bed with same red shirt on with food stains on the front and was reading a book. During an observation on 02/29/12 at 2:14 PM the door to Resident #23's room was open and she was lying across her bed asleep with the same red shirt on with food stains on the front. During an interview on 02/29/12 at 2:41 PM Nursing Assistant (NA) #1 stated Resident #23 was scheduled to have a shower or bath every day either on first or second shift. He further stated Resident #23 did not usually refuse a bath or refuse to change her clothes when he cared for her but sometimes she refused to let him change the linens on her bed. He stated he thought she was supposed to get a bath tonight on second shift. During an interview on 02/29/12 at 3:10 PM with LN #1 she stated Nursing Assistants (NAs) assisted Resident #23 daily with her care. She stated sometimes Resident #23 refused to take a shower and it was her expectation when a resident refused care the NAs should re-approach the resident at a later time and if the resident continued to refuse the NAs should tell the nurse. LN #1 stated the NAs had not reported to her that Resident #23 had refused to have her	F 241		

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F 241	Continued From page 5 clothing changed. During an observation on 02/29/12 at 5:25 PM the door to Resident #23's room was open and she was sitting on the side of her bed holding her head in her hands. She was wearing the same red shirt with food stains on the front and her nails were long with broken edges and brown debris under the nails. During an interview on 03/01/12 at 8:06 AM Resident #23 stated she had a shower and was dressed in clean clothing last night but stated she did not have any nail care during her shower. During an interview on 03/01/12 at 3:27 PM the Director of Medical Records verified there was no documentation that Resident #23 had refused to allow staff to change her soiled shirt. She stated when a resident refused care the NA should tell the nurse and the nurse should document it in the medical record. During an interview on 03/01/12 at 4:06 PM the Director of Nursing (DON) stated it was her expectation residents were to be clean and their clothes changed in the morning during AM care and at night during PM care. She explained residents should have their clothes changed during the day when they were soiled and NAs should provide nail care when the resident had a shower. She further stated when a resident refused personal care or to have clothes changed the NA should notify the nurse or DON. She verified there was no documentation that Resident #23 refused to have her shirt changed on 02/28/12 or 02/29/12. She further stated she trimmed Resident #23's nails approximately two	F 241		

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weeks ago and was not aware the resident wanted her nails trimmed.

During an interview on 03/02/12 at 11:19 AM with NA #8 she stated she worked first shift on 02/28/12 and she thought she gave Resident #23 a shower at approximately 10:30 AM and she did not know why Resident #23 had the soiled shirt on 02/28/12 or 02/29/12.

During a telephone interview on 03/02/12 at 10:07 AM NA #3 stated he gave Resident #23 a shower on second shift on 02/29/12 and put clean clothes on her after her shower. He verified he assisted the resident to remove a red top that had food stains on the front of it. He further stated she had a good shower because she really needed one. He explained Resident #23 had never refused to allow him to put clean clothing on her but it all depended on how you approached her. He stated he did not think about doing nail care because he was focused on getting her shower done.

2. Resident #2 was admitted to the facility with the diagnoses paraplegia and seizure disorder. Speech Therapy notes dated 01/19/12 revealed Resident #2 had decreased risk of aspiration due to use of compensatory strategies: slow pace, small bites and sips, liquid wash and chin tuck. Resident #2 required occasional verbal reminders to use strategies as he was easily distracted by sound and movement. Review of Resident #2's most recent quarterly Minimum Data Set (MDS) dated 02/14/12 revealed he had severe cognitive impairment. Further review of the MDS revealed Resident #2 needed supervision, encouragement by cueing, and set up only during meals. The MDS also revealed the resident had no issues

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F 241	Continued From page 7 with swallowing. Review of Resident #2's care plan updated 02/21/12, revealed he had an alteration in activities of daily living due to decreased cognitive ability. Approaches used by staff during meals included open all cartons and plastic on meal tray as needed and set up and assist and/or cue as needed. An observation was made on 02/27/12 at 12:24 PM of the Director of Nursing (DON) feeding Resident #2 in the facility's main dining room. Resident #2 was seated in his geri-chair alone at a table and there was a dining chair at this table that was not being used. During the meal the DON stood to the side, leaning over the resident and fed him the entire meal. Other staff were observed to be seated while they fed residents in this dining room. On 03/02/12 at 9:10 AM an interview was conducted with the DON. The DON reported she needed to feed the resident because he was easily distracted. She further stated that staff can sit or stand to feed residents, but it would depend on how a resident was positioned. She confirmed that she did not sit while feeding Resident #2 in the dining room but should have sat down next to him as she fed him.	F 241		
F 279 SS=D	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	F 279	*F-279* The facility will continue to use the results of the assessment to develop, review, and revise the resident's comprehensive care plan.	

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Continued From page 8

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:

Based on medical record review and staff interview the facility failed to develop a comprehensive plan of care for one (1) of twenty-one (21) sampled residents. The facility failed to develop a plan of care for Resident #35 which included the use of antipsychotic medications.

The findings are:

Resident #35 was admitted to the facility on 06/15/11 with diagnoses that included Alzheimer's dementia, depression and agitation. Review of the resident's 06/15/11 admission physician's orders revealed an order for three (3) milligrams of Risperdal (an antipsychotic medication) to be administered each day. Review of Resident #35's physician orders and medication administration records (MAR) from

F 279

Comprehensive care plan for use of antipsychotic medication was implemented for resident #35.

An audit was completed on all residents prescribed psychotropic medications to ensure correct care plans were in place.

The Interdisciplinary Team was inserviced on the care planning process by the Corporate MDS Director.

All orders will be reviewed in AM Clinical meeting to ensure if any new psychotropic orders have been written the previous day. Any new orders with psychotropic medications will then be care planned.

The A.D.O.N./MDS Coordinator will conduct care plans audits for the residents triggering for psychotropic medications weekly/x4 weeks, and then monthly thereafter to ensure appropriate care plans are in place.

Compliance will be monitored by the monthly QA committee for the next 2 months or until resolved. Additional education/training will be provided for any issues identified.

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F 279	Continued From page 9 06/15/11 to 03/02/12 revealed the continued use of antipsychotic medications. Review of Resident #35's Minimum Data Set (MDS) of 06/22/11 revealed the area of antipsychotic medications was "triggered" for further review and staff decided to "proceed" with the development of a plan of care in the area of antipsychotic medications. Review of Resident #35's care plans since her 06/15/11 admission to the facility, revealed the care plan was reviewed by facility staff on 07/26/11, 09/23/11 and 12/20/11, but a plan of care was not developed by staff to address the resident's continued use of antipsychotic medications. Interview with the facility's Director of Nursing (DON) on 03/02/12 at 12:35 PM confirmed Resident #35 had received antipsychotic medications, including Risperdal, since her admission to the facility, but a plan of care was not developed to address the use of these medications. The DON stated that she would have expected staff to develop a plan of care that addressed the resident's continued use of antipsychotic medications and the potential side effects involved with this type of medication.	F 279	Continued compliance will be monitored through review of new orders in the AM Clinical meeting, record reviews, and through the facility's Quality Assurance program.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	*F-280* The facility will continue to develop, periodically review, and revise care plans based on resident assessment. Resident #53's care plan was revised to include "must be supervised during toileting."	

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F 280	Continued From page 10 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews, medical record review, and facility accident investigation review, the facility failed to add a fall intervention to the care plan for one (1) of twenty-one (21) residents reviewed for care plans (Resident #53). The findings are: Resident #53 was admitted to the facility with diagnoses of congestive heart failure and dementia. The latest Minimum Data Set (MDS) dated 02/05/12 revealed the resident had severe cognitive impairment and required extensive assistance with toilet use. The MDS also revealed a history of falls. A review of a facility incident/accident report and a related nursing note revealed that on 12/07/11 Nursing Assistant #4 placed Resident #53 on the toilet and stepped away "for a short period." When NA #4 returned, the resident was found on	F 280	All residents were assessed for falls risk and care plans were revised to ensure appropriate interventions are in place. The Interdisciplinary Team was inserviced on the care planning process by the Corporate MDS Director. A QA monitoring tool will be utilized by the nursing staff to ensure all incidents regarding falls will be appropriately care planned and interventions put in place. The D.O.N./designee will complete audits on the resident care plans to ensure appropriate interventions have been documented per policy daily/x2 weeks, and then weekly/x2 months. Compliance will be monitored by the monthly QA committee for the next two months or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through record review and through the facility's Quality Assurance Program.	

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F 280	Continued From page 11	F 280		

the floor, uninjured. According to the incident report, Resident #53 stated "I thought I could make it to my chair and it rolled away." The incident/accident report investigation included a recommendation that the resident should not be left alone on the toilet.

Review of the resident's care plan, revised 02/12/12, revealed he had the potential for injury due to his unsteady gait, history of falls, and cognitive decline with poor safety awareness. One intervention included use of a personal alarm when the resident was unattended in bed or in his wheelchair. The care plan did not address leaving the resident alone in the toilet.

On 03/02/12 at 10:38 AM the Assistant Director of Nursing (ADON) was interviewed. She stated she had investigated the fall on 02/05/12 and completed the incident/accident report. She stated that at the time the resident was on the toilet, the alarm was not on him. She also stated that the NA should not have left the resident alone on the toilet due to the resident's poor decision making skills and fall risk. The ADON stated that she had made the recommendation on the incident/accident report for the intervention that the resident should not be left alone on the toilet. She stated that any recommendation for intervention from the incident/accident report should have been added to the care plan and to the Nurse Aide's Information Sheet so that NAs would know how to care for the resident. The ADON stated this intervention had not been added to either. She was not sure how it was missed.

On 03/02/12 at 11:08 AM the Director of Nursing

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F 280	Continued From page 12 (DON) was interviewed. The DON stated that any care interventions from the fall investigation should have been placed on the care plan and the Nurse Aide's Information Sheet so NAs would know how to care for the resident.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record reviews the facility failed to provide one (1) of one (1) sampled residents, with physician's ordered adaptive equipment to make the resident as independent as possible with eating. (Resident #60) The findings are: Resident #60 was admitted to the facility with diagnoses of lack of coordination and dementia. Review of Resident #60's Minimum Data Set (MDS) dated 12/16/11 specified that he required limited assistance with eating. Review of Resident #60's care plan, updated on 12/20/11, contained a "Problem/Need" which specified that he had an alteration in Activities of Daily Living (ADL) function due to decreased cognitive ability with poor safety awareness and weakness from advancing disease process. An approach within the plan of care directed staff to assist with feeding as needed.	F 311	***F-311*** The facility will continue to provide appropriate treatment and services to maintain or improve his or her abilities. Resident #60 has his adaptive equipment present for each meal as ordered. An audit was completed on facility residents with orders for adaptive equipment which included equipment needed with meals. The Dietary and Nursing staff were inserviced regarding residents with orders for adaptive equipment. Residents having orders for adaptive equipment have documentation on the resident care card, care plan, and tray ticket to ensure all staff aware of orders. Pictures were taken of specific adaptive equipment and placed in resident care card notebook for staff information.	

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F 311	Continued From page 13 On 01/02/12 a physician's order was written for Occupational Therapy (OT) to evaluate and treat Resident #60. Review of an OT note dated 01/02/12 specified that Resident #60 was provided with a "built up handled spoon" and he was able to feed himself with moderate cues and stand by assistance. On 01/03/12 a physician's order was written for dietary to add a built up handled spoon to the resident's meal trays at each meal. Review of Resident #60's OT discharge summary dated 01/18/12 specified that he demonstrated increased functional performance with self-feeding. Observations on 02/29/12 at 8:31 AM revealed Resident #60 was in his room with his breakfast meal tray. Items served on the meal tray included; a fried egg, toast, oatmeal, milk, orange juice and a nutritional supplement. Review of the resident's meal tray slip specified a "special spoon" was provided at meals, but only a regular spoon was observed on his meal tray. The resident stated that he did not receive his "big spoon" with this meal and was able to grasp the larger spoon better than the regular spoon that he was served at this meal. Further observations of Resident #60 on 02/29/12 from 8:31 AM to 9:13 AM revealed that he was able to consume fluids independently, but was unable to hold the regular spoon to eat his breakfast meal. Resident #60 was observed to drop the regular spoon twice as he attempted to use the spoon to eat oatmeal. After dropping the regular spoon a second time he made no further attempts to use the spoon and staff did not offer him the adaptive spoon to eat his breakfast meal. On 02/29/12 at 9:13 AM staff was observed to bring Resident #60's finished meal tray from his room. Observations of	F 311	A QA Monitoring tool will be utilized by the Dietary Manager/designee to ensure compliance of all adaptive feeding equipment at meal time every shift/x2 weeks, and then daily/x4 weeks. Compliance will be monitored by the monthly QA committee for the next two months or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored by the inventory audits, meal tray audits, and through the facility's Quality Assurance Program.	

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F 311	Continued From page 14 Resident #60's finished meal tray revealed he ate only bites of oatmeal, consumed none of the eggs or toast and consumed all of the fluids served on the meal tray, Observations of Resident #60 on 03/01/12 at 8:30 AM revealed he was in his room eating his breakfast meal with a large handled spoon. The resident was observed to use the adaptive spoon to independently eat the foods served on his breakfast meal tray without difficulty. On 03/01/12 at 8:45 AM Nursing Assistant (NA) #2, who worked with Resident #60, was interviewed. NA #2 stated the large handled spoon Resident #60 used to eat his breakfast meal on 03/01/12 was the "special spoon" he received at meals. NA #2 stated that Resident #60 could hold onto the large handled spoon better than a regular spoon. NA #2 explained that the kitchen staff were responsible for providing the spoon to the resident at meals. Interview with the facility's Dietary Manager (DM) on 03/01/12 at 9:20 AM revealed dietary staff should provide Resident #60 with a large handled spoon at each meal. The DM stated that dietary staff should be informed if an adaptive spoon is not provided on Resident #60's meal trays, so it can be provided to the resident as ordered.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	*F-312* The facility will continue to ensure residents who are unable to carry out activities of daily living receive the	

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F 312	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record reviews facility staff failed to change resident's soiled clothing and provide nail care to three (3) of eighteen (18) sampled residents. (Residents #23, #71 and #74). The findings are: 1. Resident #23 was admitted with diagnoses including diabetes, heart failure, anxiety, depression, chronic lung disease and tracheostomy. The most recent annual Minimum Data Set (MDS) dated 01/20/12 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The MDS also indicated Resident #23 required extensive assistance by staff for bathing, limited assistance with hygiene and dressing, and was always continent of bladder and bowel. The MDS further indicated preferences for Resident #23's customary routine and activities and it was very important for her to choose clothes to wear, take care of personal belongings and choose tub, bath, shower or sponge bath. A review of a care plan dated 01/20/12 revealed a problem statement for alteration in activities of daily living (ADL) due to unsteady gait at times and weakness from recent upper respiratory infection. Interventions were listed to encourage resident to pick out her own clothes and set up and assist and/or cue resident as needed.	F 312	necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #23 was given a complete shower which included nail care and a change of clothing. Resident #71 was provided oral care, nail care, and hair was combed. Resident #74 had chin hair removed and nail care was provided. All resident care plans were reviewed by IDT to ascertain appropriateness of care plans. All residents were accessed for proper skin and nail care per individual care plan and grooming completed. Facility staff was in-serviced on dignity issues, skin care, resident rights and approaches. This included nail care, changing clothing per resident choice and alternate approaches to accomplish care needed. A QA Monitoring tool "Management Rounding Sheet" will be utilized by the D.O.N./designee to ensure compliance of ADL care and	

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F 312	Continued From page 16 During an observation on 02/28/12 at 8:45 AM the door to Resident #23's room was open and she was sitting on the side of her bed. She was wearing a red shirt with food stains on the front of her shirt and her fingernails on each hand were long and broken and had brown debris under the nails. During an interview on 02/28/12 at 8:50 AM Resident #23 stated she had just finished her breakfast but she spilled some of it on her shirt and was waiting for her shower. During an observation on 02/28/12 at 10:55 AM the door to Resident #23's room was open and she was sitting on the side of her bed with the same red shirt on with food stains on the front of her shirt. During an interview on 02/28/12 at 11:00 AM Resident #23 stated she was still waiting for her shower and she expected it to be done today. During an observation on 02/28/12 at 1:50 PM the door to Resident #23's room was open and she was sitting on the side of her bed with the same red shirt on with food stains on the front and was reading a book. During an observation on 02/29/12 at 8:36 AM the door to Resident #23's room was open and she was sitting on the side of her bed with the same red shirt on with food stains on the front. During an interview on 02/29/12 at 8:36 AM Resident #23 stated she did not get her shower yesterday and she slept in the same clothes she	F 312	grooming needs are completed daily/x2 weeks, and then weekly/x4 weeks. Compliance will be monitored by the monthly QA committee for the next two meetings or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through routine rounds, audits, and through the facility's Quality Assurance Program.	

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wore yesterday.

During an observation and interview on 02/29/12 at 9:05 AM Resident #23 held out her hands and the nails on both hands were long and broken and had brown debris under each nail.

During an interview on 02/29/12 at 9:08 AM Resident #23 stated she did not routinely get nail care unless she requested it.

During an observation on 02/29/12 at 11:33 AM the door to Resident #23's room was open and she was sitting on the side of the bed with same red shirt on with food stains on the front reading a book.

During an observation on 02/29/12 at 2:14 PM the door to Resident #23's room was open and she was lying across her bed asleep with the same red shirt on with food stains on the front.

During an interview on 02/29/12 at 2:41 PM Nursing Assistant (NA) #1 stated Resident #23 was scheduled to have a shower or bath every day either on first shift or second shift. He further stated Resident #23 did not usually refuse a bath or refuse to have her clothing changed when he cared for her but sometimes she refused to let him change the linens on her bed. He stated thought she was supposed to get a bath tonight on second shift.

During an interview on 02/29/12 at 3:10 PM with LN # 1 she stated Nursing Assistants (NA's) assisted Resident #23 daily with her care. She stated sometimes Resident #23 refused to take a shower and it was her expectation when a

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F 312	Continued From page 18 resident refused care the NA's should re-approach the resident at a later time and if the resident continued to refuse the NA's should tell the nurse. LN #1 stated the NA's had not reported to her that Resident #23 had refused to have her clothing changed. During an observation on 02/29/12 at 5:25 PM the door to Resident #23's room was open and she was sitting on the side of her bed holding her head in her hands. She was wearing the same red shirt with food stains on the front and her nails were long with broken edges and brown debris under the nails. During an interview on 03/01/12 at 8:06 AM Resident #23 stated she had a shower and was dressed in clean clothing last night but stated she did not have any nail care during her shower. During an interview on 03/01/12 at 3:27 PM the Director of Medical Records verified there was no documentation that Resident #23 had refused to allow staff to change her soiled shirt. She stated when a resident refused care the NA should tell the nurse and the nurse should document it in the medical record. During an interview on 03/01/12 at 4:06 PM the Director of Nursing (DON) stated it was her expectation residents were to be clean and their clothes changed in the morning during AM care and at night during PM care. She explained residents should have their clothes changed during the day when they were soiled and NA's should provide nail care when the resident had a shower. She further stated when a resident refused personal care or to have clothes changed	F 312		

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the NA should notify the nurse or DON. She verified there was no documentation that Resident #23 refused to have her shirt changed on 02/28/12 or 02/29/12. She further stated she trimmed Resident #23's nails approximately two weeks ago and was not aware the resident wanted her nails trimmed.

During an interview on 03/02/12 at 11:19 AM with NA #8 she stated she worked first shift on 02/28/12 and she thought she gave Resident #23 a shower at approximately 10:30 AM and she did not know why Resident #23 had the soiled shirt on 02/28/12 or 02/29/12.

During a telephone interview on 03/02/12 at 10:07 AM NA #3 stated he gave Resident #23 a shower on second shift on 02/29/12 and put clean clothes on her after her shower. He verified he assisted the resident to remove a red top that had food stains on the front of it. He further stated the resident had a good shower because she really needed one. He explained Resident #23 had never refused to allow him to put clean clothing on her but it all depended on how you approached her.

2. Resident #71 was admitted to the facility on 01/21/12 with the diagnoses muscle weakness, shortness of breath and lung cancer. Review of Resident #71's Minimum Data Set (MDS) dated 01/27/12 revealed she was cognitively intact. Further review of the MDS revealed she needed extensive assistance with all activities of Daily living (ADL). Review of Resident #71's care plan updated 02/23/12 revealed she had an alteration in activities of daily living related to weakness from advancing disease process. The goal was

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F 312	Continued From page 20 for staff to anticipate Resident #71's needs. Interventions included set up the resident for oral care and encourage participation, and provide assistance and care as needed. An observation was made on 02/27/12 at 9:30 AM of Resident #71 sitting on the side of the bed wearing a navy blue T-shirt and an incontinence brief only. Resident #71 was talking with the speech pathologist who worked at the facility. An observation was made on 02/27/12 at 4:28 PM of Resident #71 sitting in her room wearing the same T-shirt she had been wearing earlier in the day. Her hair was uncombed and she had a large amount of debris in her top and bottom teeth. Her T-shirt had white flakes down the front. An observation was made on 02/28/12 at 2:00 PM of Resident #71 wearing the same navy blue T-shirt she had worn the previous day. An observation was made on 02/29/12 at 10:24 AM of Resident #71 wearing the same navy blue T-shirt she had been wearing for the previous two days. Resident #71 continued to have a large amount of debris in her teeth, her hair was uncombed, and she had brown debris under her three of her fingers on her left hand. On 03/01/12 at 9:44 AM an interview was conducted with Resident #71. She reported she refused her bath the previous night as she was nauseated. Resident #71 reported staff had not done nail care for her. Showing her finger nails, she stated, "Look how dirty they are." She reported staff did change her shirt last night. She further reported that staff had not provided mouth	F 312		

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care, nor had they brought her a toothbrush so she could brush her own teeth. She stated she is unable to get to the bathroom on her own.

On 03/01/12 at 10:16 AM an interview was conducted with Licensed Nurse (LN) #3 who worked with Resident #71. LN #3 reported he had not had any reports of Resident #71 refusing care. He further reported Resident #71 wanted to be independent and won't ask for help but she needs assistance.

On 03/01/12 at 11:15 AM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON reported she had approached Resident #71 to assist her with brushing her teeth and providing nail care but the resident had refused. The ADON stated that when she went back a few moments later the resident allowed her to provide care. She stated her expectation was for the nursing assistants (NAs) to provide care for the residents. She further reported that if residents refused care she expected the nursing assistants to try harder by going back to offer assistance with care or to get another nursing assistant to try.

On 03/02/12 at 2:30 PM an interview was conducted with NA #5 who had worked with Resident #71 on 02/27/12 - 02/28/12. NA #5 stated that Resident #71 wanted to be independent but confirmed the resident did need assistance and she was unable to do it herself. She explained that she should have given Resident #71 assistance by changing her clothes and providing her with mouth care.

An interview was conducted on 03/02/12 at 2:36

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F 312	Continued From page 22 PM with the Director of Nursing (DON). The DON reported that she expected NAs to keep trying to provide care if a resident refused. She further expected the NAs to provide residents with what they needed in order to do ADL care as they were able, to keep them as independent as possible. She further explained that mouth care should be done each morning and night and a resident's clothing should be changed whenever it was soiled as well as in the morning and at night. 3. Resident #74 was admitted to the facility on 02/14/12 with the diagnoses of muscle weakness and pressure ulcer. Review of Resident #74's admission Minimum Data Set (MDS) revealed she was cognitively intact and needed extensive assistance with activities of daily living. Review of Resident #74's care plan dated 02/16/12 revealed she had an alteration in activities of daily living function due to decreased cognitive ability with poor safety awareness and weakness from advancing disease process. The care plan goal for this issue was that staff would anticipate the needs of the resident. An observation was made 02/27/12 at 3:45 PM of Resident #74. The resident was observed to have chin hairs that were approximately one-forth (1/4) of an inch long. The resident also had one long dark hair at the corner of her mouth measuring approximately three quarters (3/4) of an inch long and had several long and jagged fingernails. An interview was conducted on 02/27/12 at 3:45 PM with Resident #74. The resident reported she had received a shower that day but staff did not trim her finger nails or her chin hairs. She reported that staff appeared to be in a rush while	F 312		

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F 312	Continued From page 23 they provided her care. An interview was conducted on 02/29/12 at 3:09 PM with Nursing Assistant (NA) #5. NA #5 reported that she gave Resident #74 a bath on 02/27/12. The NA stated that during showers staff are expected to trim fingernails and shave chin hairs. She explained that she did not pay attention to Resident #74's fingernails or her chin hairs when she gave her a shower on 02/27/12. ON 03/02/12 at 10:16 AM an interview was conducted with Resident #74. The resident stated that staff had given her a shower on the previous day. She explained that staff trimmed her fingernails, but did not trim her chin hairs. An interview was conducted on 03/02/12 at 10:32 AM with NA #6. NA #6 confirmed that she had given Resident #74 a shower on the previous day. The NA reported that a resident's fingernails and chin hairs should be done when showers are provided. She stated the resident did not want her chin hairs done as she just wanted to put her feet up. She further reported that she should have asked the resident again if she could shave her chin hairs. An interview was conducted on 03/02/12 at 2:36 PM with the Director of Nursing (DON). The DON explained that care during showers should include trimming and cleaning of finger nails. She further reported that if a resident refused care the NAs should continue to try to provide the care the resident needs.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 24 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to identify a change in skin conditions and initiate timely treatment for two (2) of five (5) residents with facility acquired pressure sores. (Residents #42 and #33) The findings are: 1. Resident #42 was admitted to the facility on 12/29/08 with diagnoses including; dementia, diabetes mellitus, debility, chronic obstructive pulmonary disease, peripheral vascular disease, muscle weakness, osteoarthritis, bipolar disorder and neuropathy. Review of Resident #42's Minimum Data Set dated 11/10/11 revealed he required total assistance with bed mobility, required extensive assistance with transfers and personal hygiene and required staff assistance to move sufficiently to relieve pressure over any one site. The assessment specified that Resident #42 did not have pressure ulcers at this time.	F 314	*F-314* The facility will continue ensure resident having pressure sores receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Resident #42 is receiving necessary treatment as ordered and wound is decreasing in size and severity. Resident #33's physician was notified and the laxative orders were changed. The wound is currently healed and preventative measures are in place to prevent recurrence. All residents were audited for skin risk and evaluated to ensure appropriate interventions are in place to prevent skin breakdown. Nursing staff were inserviced on skin assessment and proper communication / documentation. A QA Monitoring tool will be utilized by the D.O.N./designee to ensure compliance of all skin assessments every shift/x2 weeks, and then daily/x4 weeks.	

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F 314	Continued From page 25 Review of Resident #42's current care plan revealed a "Problem/Need", with an onset date of 12/17/10, identified him as being at risk for skin breakdown due to incontinence of bladder and bowel. The care plan's goal specified to monitor for skin breakdown daily. A care plan approach included; to check the resident periodically, offering toileting and change as needed for skin maintenance and hygiene. Further review of the resident's current care plan revealed "Problem" areas, with onset dates of 12/17/10, that addressed his diagnosis of Diabetes and his inability to reposition himself without assistance. Approaches included for these care plans areas included; "Special monitoring of skin for redness or circulatory problems", "Monitor and assure position changes", "Check resident frequently for positioning" and "Monitor skin for redness or breakdown." Review of Direct care Activity of Daily Living (ADL) Documentation from 01/12/12 to 01/14/12 revealed that Resident #42 was dependent on staff for bed mobility, transfer and personal hygiene. Review of the resident's nursing notes revealed a note written on 01/14/12 that specified the resident had developed a black area on his left heel which measured 1.3 centimeters (cm) wide by 2 cm long by 0.1 cm deep with no signs and symptoms of infection. On 01/14/12 a physician's order was written to initiate treatment to Resident #42's left heel pressure ulcer.	F 314	Compliance will be monitored by the monthly QA committee for the next two meetings or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through on-going skin observations, record reviews, and through the facility's Quality Assurance Program.	

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On 02/29/12 at 2:41 PM an observation was made of the Director of Nursing (DON) performing a dressing change to Resident #42's left heel. During this dressing change the resident's left heel pressure ulcer was observed to measure 3 cm wide by 2 cm long by 0.2 cm deep with black eschar. The DON confirmed Resident #42's left heel wound was a pressure ulcer that had become larger since it was initially observed by staff on 01/14/12.

On 03/01/12 at 3:50 PM Nursing Assistant (NA) #8, who regularly provided care to Resident #42 during the previous 3 months, was interviewed. NA #8 stated that Resident #42 was dependent on staff for care, including turning and repositioning. NA #8 further stated that staff were to check Resident #42's skin during care and were expected to report any signs of breakdown, including skin redness, to the nurse.

On 03/02/12 at 12:50 PM Licensed Nurse #4, who was familiar with Resident #42, was interviewed. LN #4 stated that Resident #42 required extensive and total care during the months of December 2011 and January 2012. The LN stated that she recalled the expectation was that nursing assistants would check Resident #42's skin every two (2) hours during care rounds which included turning and repositioning and during showers and were to report anything that was not normal including the development of reddened areas. LN #4 further stated that since Resident #42 was diabetic the NAs should have monitored his feet closely for problems, but was unsure if the resident's Nursing Assistant Flow record noted any information for special skin

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F 314	Continued From page 27 monitoring. On 03/02/12 at 1:30 PM an interview was conducted with the facility's Director of Nursing (DON). The DON confirmed that Resident #42's wound on the left heel was a pressure ulcer that was facility acquired. The DON stated that the resident's current Nursing Assistant worksheet, which was in place prior to 01/14/12 did not note any special skin monitoring, but since Resident #42 was a diabetic staff should have monitored his skin and feet closely. The DON stated that she would have expected for staff to have identified and reported any concerns about the resident's left heel ulcer to the nurse before it progressed to a blackened area as first identified by staff on 01/14/12. 2. Resident #33 was most recently readmitted to the facility on 10/01/11 with diagnoses which included dementia, history of bowel obstruction and renal insufficiency. Review of Resident #33's physician orders revealed three laxatives were ordered on 10/01/11: Dulcolax 5 milligrams one (1) tablet by mouth twice daily, Miralax Powder 17 grams twice daily, and Senokot-S one (1) tablet twice daily. Review of Resident #33's most recent Minimum Data Set (MDS) dated 12/26/11, revealed the resident had long and short term memory loss and was not able to participate in daily decision making. Further review of the MDS revealed Resident #33 was totally dependent for bed mobility and transfers and had two (2) stage two pressure ulcers. The MDS further revealed the resident was incontinent of bowel. Further review of the medical record revealed Resident #33 was	F 314		

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assessed to be at high risk for pressure ulcers.

Review of Resident #33's current care plan, updated on 12/26/11, identified him as being at risk for skin breakdown due to daily incontinence of bowel and bladder, having an inability to reposition self without assistance and having an alteration in Activity of Daily Living (ADL) function due to impaired cognition. Approaches within this resident's plan of care included; "Good pericare after each incontinent episode," "Turn and reposition Resident on routine rounds and PRN (as needed)" and "Monitor skin for redness or breakdown."

Review of bowel records dated February 2012 revealed the resident averaged between two (2) and eight (8) bowel movements per day.

Review of the February 2012 Treatment Administration Records (TAR) revealed Resident #33 had two (2) new facility acquired stage two pressure ulcers noted on 02/01/12, one on the right buttock and one on the left buttock.

Review of a physician's note dated 02/17/12 revealed the resident had diarrhea from all the laxatives he was taking which were ordered due to history of bowel obstruction. The physician further noted Resident #33 had developed pressure ulcers on either side of his buttocks due to the diarrhea and immobility.

A physician's order dated 02/17/12 revealed an order to discontinue the Dulcolax 5 mg twice daily.

On 02/29/12 at 4:00 PM an observation was

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made of Resident #33's pressure ulcer. A pressure ulcer was noted on each buttock. The pressure ulcers were covered with a clear dressing. The wounds showed no sign or symptoms of infection.

On 03/02/12 at 11:40 AM an interview was conducted with Nursing Assistant (NA) #7 who frequently cared for Resident #33. NA #7 reported for the last few months Resident #33 had been having frequent large, liquid stools. He reported on 03/01/12 Resident #33 had at least four (4) very large, liquid stools on his shift (7AM-3PM).

On 03/02/12 at 9:10 AM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #33 had two (2) pressure ulcers that were caused by uncontrollable diarrhea. She further reported the doctor was aware of the diarrhea but she did not know if he was aware of the frequency of the loose stools. The interview further revealed the resident had a pressure ulcer on his coccyx that was discovered on 10/02/11 which had healed but reopened 02/01/12 due to the uncontrollable diarrhea. The DON was not able to produce documentation regarding when the original pressure ulcer on his coccyx healed.

On 03/02/12 at 12:00 PM, an interview was conducted with Resident #33's physician. The physician reported he knew the resident was having diarrhea but was unaware of the frequency of the diarrhea. The physician stated that had he been made aware of the frequency of Resident #33's diarrhea he probably would have decreased the resident's laxative medication

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F 314	Continued From page 30 sooner than 02/17/12.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, medical record reviews, and facility accident investigation review, the facility failed to monitor a resident during toileting, place a fall mat beside a low bed, and place a personal alarm on a resident for two (2) of three (3) sampled residents with a history of falls (Residents #53 and #62). The findings are: 1. Resident #53 was admitted to the facility with diagnoses of congestive heart failure and dementia. The latest Minimum Data Set (MDS) dated 02/05/12 revealed the resident had severe cognitive impairment and required extensive assistance with most activities of daily living. The MDS also revealed a history of falls. Review of the resident's care plan, revised 02/12/12, revealed he had the potential for injury due to his unsteady gait, history of falls, and cognitive decline with poor safety awareness. One intervention included use of a personal alarm	F 323	*F-323* The facility will continue to ensure the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistive devices to prevent accidents. The care plan for Resident #53 was revised to include "must be supervised during toileting." The personal alarm was reconnected and placed out of the resident's reach. The fall mat was placed beside the bed during survey. An order was written for the personal alarm and placed on the MAR for Resident #62. The personal alarm was applied to the resident immediately when observed unclipped during survey. All facility residents were audited to ascertain fall risk and appropriate interventions are in place.	

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F 323	Continued From page 31 when the resident was unattended in bed or in his wheelchair. A review of a facility incident/accident report and a related nursing note revealed that on 12/07/11 Nursing Assistant (NA) #4 placed Resident #53 on the toilet and stepped away "for a short period." When NA #4 returned, the resident was found on the floor, uninjured. According to the incident report, Resident #53 stated "I thought I could make it to my chair and it rolled away." On 03/02/12 at 10:38 AM the Assistant Director of Nursing (ADON) was interviewed. She stated she had investigated the fall. She stated that at the time the resident was on the toilet, the alarm was not on him. She also stated that the NA should not have left the resident alone on the toilet due to the resident's poor decision making skills and fall risk. She further stated that any resident who wore an alarm should not be left alone on the toilet without the alarm. On 03/02/12 at 11:08 AM the Director of Nursing (DON) was interviewed. The DON stated all nursing assistants had been inserviced before the fall on 12/07/11 not to leave any resident who is a fall risk alone on the toilet. She stated she expected NA #4 not to leave Resident #53 alone on the toilet. On 03/02/12 at 2:50 PM, NA #4 arrived at the facility and was interviewed. He stated he should not have left Resident #53 alone on the toilet due to his fall risk. 2. Resident #53 was admitted to the facility with diagnoses of congestive heart failure and	F 323	All nursing staff were in-serviced regarding fall procedures and interventions which include; if a resident is on a low bed, no side rails are to be used, and fall mats if ordered, are to be in place whenever resident is in bed. New CNA Care Cards have been implemented with all new interventions in place and care planned. All nursing staff were in-serviced on new Care Cards and how they are to be used. A QA Monitoring tool "Fall Monitoring Audit – Interventions QA" sheet, will be utilized by the D.O.N./designee to ensure compliance of occurrence reports daily/x2 weeks, and then weekly/x2 months. Compliance will be monitored by the monthly QA Committee for the next two meetings or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through audits, random record reviews, and through the facility's Quality Assurance Program.	

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F 323	Continued From page 32 dementia. The latest Minimum Data Set (MDS) dated 02/05/12 revealed the resident had severe cognitive impairment and required extensive assistance with most activities of daily living. The MDS also revealed a history of falls. Review of the resident's care plan, revised 02/12/12, revealed he had potential for injury due to his unsteady gait, history of falls, and cognitive decline with poor safety awareness. Interventions included a low bed against the wall, a fall mat on the floor beside the bed, and use of a personal alarm. The Nurse Aide's Information Sheet, which is the version of the care plan used by nursing assistants to know what care is required for each resident, was reviewed. It noted Resident #53 required a low bed with a fall mat on the floor and a personal alarm. The Sheet also instructed the nursing assistant to keep the alarm box and the connector out of reach of the resident. On 03/02/12 at 11:08 AM, Resident #53 was observed in his bed. The bed had one side against the wall and was in the lowest position. There was no fall mat on the floor and the side rail was raised on the open side of the bed. The personal alarm was present on the bed, but the resident stated he had just unclipped the alarm from his shirt. The Director of Nursing (DON) was present for this observation and was interviewed at that time. She stated the resident often removed his alarm. She stated the fall mat should have been in place on the floor by the bed but noted it was in the resident's closet. She stated she expected staff not to raise the side rail on a low bed with a fall mat because if a resident attempted to get out of	F 323		

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bed over the rail, they would have farther to fall. The DON reconnected the personal alarm in a place the resident could not reach, placed the fall mat on the floor by the bed, and lowered the side rail.

On 03/02/12 at 12:15 PM, Nursing Assistant #1 was interviewed. He stated Resident #53 required a low bed with a fall mat on the floor beside the bed and use of a personal alarm. He stated he forgot to place the fall mat by the bed when he laid the resident down. He stated he raised the side rail on the resident's bed for safety.

3.) Resident #62 was admitted to the facility with Parkinson's Disease and psychotic disorder. The latest Minimum Data Set dated 01/27/12 revealed the resident was cognitively intact and required limited to total assistance with most activities of daily living.

Review of the resident's care plan, revised 02/23/12, revealed he had potential for injury due to his unsteady gait and cognitive decline with poor safety awareness. The care plan also revealed the resident had been found on the floor on 02/23/12 and a personal alarm had been added to the care plan as an intervention. Review of the incident/accident report associated with this fall revealed that the resident had been in bed, was found on the floor, and stated that he had crawled out of bed while trying to reach something.

On 12/29/12 at 11:35 AM Licensed Nurse (LN) #1 was interviewed. She stated she was unaware that Resident #62 required use of a personal alarm. She stated all personal alarms required a

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physician order and were transcribed on the Medication Administration Record (MAR) so that nurses could check the batteries and proper placement of the alarm each shift. She stated there was no order for an alarm for Resident #62, it was not listed on the MAR, and she had not checked placement of the alarm on her shift. LN #1 then checked the resident's care plan and stated that the use of the alarm was noted on the resident's care plan.

On 02/29/12 at 12:03 PM, Resident #62 was observed in his bed. The Assistant Director of Nursing (ADON) was present during the observation and she noted that the resident's personal alarm was not on him but was lying on top of a small refrigerator next to his bed. The ADON checked the alarm to make sure it operated correctly and connected the alarm to the resident.

At the time of this observation, Nursing Assistant (NA) #2, who was assigned to Resident #62, entered the room. The ADON asked the NA about the unconnected alarm and NA #2 stated that she did not know the resident was supposed to have an alarm. The ADON confirmed that a personal alarm should be on the resident at all times when unattended in bed.

On 02/29/12 at 12:03 PM the interview with the ADON continued. She stated Resident #62 had crawled out of bed on 02/23/12 and was found on the floor. At that time, an intervention was added to the resident's care plan for an alarm when in bed. The ADON explained that when the alarm intervention had been added to the care plan, a physician order should have been obtained and

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F 323	Continued From page 35 transcribed to the MAR so the medication nurse would know to check the alarm batteries and placement each shift. She stated this had not been done. She stated a breakdown had occurred in the care planning process. On 02/29/12 at 3:07 PM, a follow-up interview was conducted with the ADON. She stated that the NAs knew how to care for each resident by consulting the Nurse Aide's Information Sheet which contained the care plan interventions including alarms. She stated the care plan intervention for the alarm had not been transferred to the Nurse Aide's Information Sheet. She stated the NAs would not know Resident #62 required an alarm unless it were on this Sheet. The ADON stated she had just obtained an order for the alarm, transcribed the alarm to the MAR, and transcribed the alarm to the Nurse Aide's Information Sheet. On 02/29/12 at 4:01 PM the Director of Nursing (DON) was interviewed and explained the process for initiation of alarms. She stated that when an alarm was used as an intervention, it must be added to the care plan, and a physician order must be obtained. If there were no physician order obtained, the alarm would not be transcribed to the MAR and the nurse would not know to check the batteries and to check placement each shift. The DON stated the care plan intervention also needed to be added to the Nurse Aide's Information Sheet. The DON stated that she expected NAs to keep a personal alarm on Resident #62 whenever he was unattended in bed due to his fall risk and history of falls. But she also stated that if the care plan intervention were not added to the Nurse Aide's Information Sheet,	F 323		

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F 323	Continued From page 36 the NAs would have no way of knowing about the care plan intervention for an alarm.	F 323		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed monitor use of laxatives for one (1) of ten (10) sampled residents reviewed for unnecessary medications. (Resident #33)	F 329	*F-329* The facility will continue to ensure each resident's drug regimen is free from unnecessary drugs, including presence of adverse consequences which indicates the dose should be reduced or discontinued. Resident #33 had laxative orders changed at the time of survey. Resident is not having any diarrhea. An audit was completed for all residents with prescribed laxatives. The physician was notified and parameters were provided for all current orders. Licensed nursing staff were in-serviced regarding proper physician notification relative to drug regimens and adverse consequences. A QA Monitoring tool will be utilized by the D.O.N/designee to ensure compliance of all laxative orders daily/x2 weeks and then weekly/x4 weeks.	

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F 329	Continued From page 37 The findings are: Resident #33 was most recently readmitted to the facility on 10/01/11 with diagnoses which included dementia, history of bowel obstruction and renal insufficiency. Review of Resident #33's physician orders revealed three laxatives were ordered on 10/01/11: Dulcolax 5 milligrams one (1) tablet by mouth twice daily, Miralax Powder 17 grams twice daily, and Senokot-S one (1) tablet twice daily. Review of Resident #33's most recent Minimum Data Set (MDS) dated 12/26/11, revealed the resident had long and short term memory loss and was not able to participate in daily decision making. Further review of the MDS revealed Resident #33 was totally dependent for bed mobility and transfers and had two (2) stage two pressure ulcers. The MDS further revealed the resident was incontinent of bowel. Further review of the medical record revealed Resident #33 was assessed to be at high risk for pressure ulcers. Review of a physician note dated 02/17/12 revealed the resident had diarrhea from all the laxatives he was taking which were ordered due to history of bowel obstruction. The physician further noted Resident #33 had developed pressure ulcers on either side of his buttocks due to the diarrhea and immobility. Review of the December 2011 Medication Administration Record (MAR) revealed Resident #33's laxatives held on 12/16/11. The January 2012 MAR revealed the laxatives were held on 01/18/12 and 01/22/12. The February 2012 MAR revealed the laxatives were held on 02/17/12.	F 329	Compliance will be monitored by the monthly QA Committee for the next two monthly meetings or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored by record audits and the facility's quality assurance programs. Additional education/training will be provided for any issues identified.	

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F 329	Continued From page 38	F 329		

Continued From page 38

A physician order dated 02/17/12 revealed an order to discontinue the Dulcolax 5 mg twice daily.

Review of bowel records dated February 2012 revealed the resident averaged between two (2) and eight (8) bowel movements per day.

On 03/01/12 at 9:28 AM an interview was done with the facility's consultant pharmacist. The pharmacist reported that he was unaware that Resident #33 had experienced frequent diarrhea. He stated these drugs (Miralax and Senna) should be held if the resident had frequent diarrhea. He also reported that he should have been informed by staff if the diarrhea had become a problem so he could have made recommendations to the physician regarding the resident's medications and laxative use.

On 03/02/12 at 10:04 AM an interview was conducted with Licensed Nurse (LN) #4. The nurse stated that she notified Resident #33's medical doctor about the resident's frequent diarrhea. LN #4 stated that she told the doctor the resident had been having three to four loose stools per day not per shift. She also reported the doctor discontinued the resident's Dulcolax twice daily. LN #4 stated that she had not reviewed the resident's bowel records since the medication was discontinued.

On 03/02/12 at 9:10AM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #33 had two (2) pressure ulcers that were caused by uncontrollable diarrhea. She further reported the

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F 329	Continued From page 39 doctor was aware of the diarrhea but she did not know if the he was aware of the frequency of loose stools the resident experienced. The interview further revealed the resident had a pressure ulcer on his coccyx that was discovered on 10/02/11 which had healed but reopened 02/01/12 due to the resident's uncontrollable diarrhea. On 03/02/12 at 12:00 PM, an interview was conducted with Resident #33's Medical Doctor. The Doctor reported that he was aware the resident was having diarrhea, but was unaware of the frequency of the diarrhea. He further stated had staff made him aware of the frequency of Resident #33's diarrhea he probably would have decreased the resident's laxative medication sooner than 02/17/12.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to serve one (1) of seven (7) sampled residents a therapeutic diet as ordered by their physician. (Resident #35) The findings are: Resident #35 was admitted to the facility on 06/15/11 with a diagnosis of Dementia and an allergy to lactose. Review of Resident #35's	F 367	*F-367* The facility will continue to ensure therapeutic diets are served as ordered. Lactose Allergy was added to the nursing assistant care card for Resident #35. All resident care plans and care sheets were reviewed to ensure appropriate interventions regarding therapeutic diets and food allergies are documented.	

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F 367	Continued From page 40 Minimum Data Set (MDS) of 12/16/11 revealed she was assessed with cognitive deficits and required limited assistance with eating. Review of Resident #35's current plan of care, last updated on 12/20/11, specified that she was at risk for weight loss due to advancing dementia. An approach on this plan of care directed staff to provide between meal snacks as appropriate with diet. Review of the resident's current physician's orders revealed a diet order for a Lactose Free diet (no milk or milk products) that was initiated on 06/15/11. Observations on 03/02/12 at 9:54 AM Resident #35 was observed in her room with an eight (8) ounce carton of milk and a six (6) ounce carton of a nutritional shake that contained skim milk positioned in front of her on an over bed table. The resident had consumed all eight (8) ounces of the whole milk and four (4) ounces of the nutritional milk shake. Interview with Nursing Assistant (NA) #7 on 03/02/12 at 10:10 AM revealed that he provided Resident #35 with the carton of milk and the nutritional shake (which contained skim milk) for a snack. NA #7 stated that he had worked with Resident #35 on a regular basis, but was unaware that she had an order for a Lactose Free diet and should not be served milk or milk products. NA #7 further stated that a resident's diet restrictions and allergies were not noted on their NA information flow sheet. NA #7 stated that he was unaware of any facility documentation that NAs could review to determine if a resident was	F 367	Nursing staff were in-serviced on proper procedure regarding residents with therapeutic diets. A QA Monitoring tool will be utilized by the D.O.N./designee to ensure compliance of therapeutic diets every shift/x2 weeks, and then daily/x4 weeks. Compliance will be monitored by the QA committee for the next two meetings or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through routine rounds, and through the facility's Quality Assurance program. Additional education/training will be provided for any issues identified.	

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F 367	Continued From page 41 on a therapeutic diet and if the resident should not be served certain foods in between meals. Interview with the facility's Dietary Manager (DM) on 03/02/12 at 10:50 AM confirmed that Resident #35 had a current physician's order for a lactose free diet and should not be served regular milk or milk products. The DM stated that soy milk was available in the kitchen when Resident #35 requested milk. Interview with the facility's Director of Nurses (DON) on 03/02/12 at 12:35 PM revealed if a resident requested a nursing assistant (NA) to provide them with a between meal snack there was no facility documentation available for the NA to review to determine if the resident was on a therapeutic diet order and if there were any foods the resident should not be served. The DON explained that NA #7 should have asked the nurse if Resident #35 had any allergies of diet restrictions prior to providing the resident with milk products for a between meal snack.	F 367		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	*F-371* The facility will continue to store, prepare, distribute and serve food under sanitary conditions. Dietary staff were in-serviced on proper preparation of pureed desserts, including appropriate temperature maintenance and including the items that must be maintained at 41 degrees or colder.	

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F 371	Continued From page 42 by: Based on observations and staff interviews the facility failed to serve pureed cake, that was prepared with milk, at a temperature of forty one (41) degrees Fahrenheit or below and failed to prevent staff, who were not wearing hair restraints, from entering the kitchen to obtain food items. The findings are: 1. An observation on 02/29/12 at 11:45 AM revealed dietary staff were preparing resident lunch meals from the kitchen's tray line. Observations of a cart that was positioned next to the tray line revealed this cart contained three (3) cups of pureed cake with milk that were ready to be served. An observation on 02/29/12 at 12:25 PM revealed two (2) of the cups of pureed cakes with milk had been served on resident trays. The Dietary Manager (DM), upon request monitored the temperature of the pureed cake with milk that had not yet been served from the tray line. The temperature of this food item was found to be elevated at sixty (60) degrees Fahrenheit. On 02/29/12 at 12:48 PM an interview was conducted with the Dietary Manager (DM). The DM reported the cake was pureed with milk to promote nutritional value. She reported the cake should have been placed on ice by staff until it was time for it to be served. The DM stated the pureed cake should have been maintained by staff at a temperature of forty one (41) degrees Fahrenheit or below while being served from the kitchen's tray line.	F 371	All dietary staff in-serviced on proper hair restraint during food service preparation and non-dietary staff are not permitted past the non-food entrance foyer. The Dietary Manager/designee will complete temperature audits on cold food items daily and document these audits on the "Cold Food Temperature QA Tool" form. The Dietary Manager/designee will monitor for ongoing compliance with hair restraint daily and document these audits on the "Daily Hairnet QA Monitoring Tool" form. Non-dietary staff is not permitted past the non-food entrance foyer leading to the Dietary Manager's office. This will be monitored daily for ongoing compliance by the Dietary Manager/designee using the "Non-Dietary Staff in Kitchen QA Tool" form. All of the above audits will be performed daily for the next two months and reported to the monthly QA Committee. Additional education/training will be provided for any issues identified.	

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On 02/29/12 at 1:15 PM an interview was conducted with the Kitchen Aide, who prepared the pureed the cake, that was served during the 02/29/12 lunch meal. The Aide reported that he normally does not put the pureed cake with milk on ice, but it should be placed on ice to ensure that it will be served from the tray line at a temperature of forty-one (41) degrees Fahrenheit or below.

2. On 02/29/12 at 8:40 AM an observation was made of a woman preparing toast in the facility's kitchen. This woman was not wearing a hair net and did not appear to be an employee. Also, during this observation Nursing Assistant (NA) #2 walked into the kitchen to retrieve a condiment while not wearing a hair net.

On 02/29/12 at 8:40 AM an interview was conducted with the Dietary Manager (DM). The DM reported the woman who was fixing toast in the kitchen was a dietary employee, but was not currently on duty. The DM further explained this employee came to the facility every morning to feed a family member who was a resident. The DM reported it was her expectation that staff stand at the kitchen's door and ask the on duty dietary staff for any items that they needed or to put on a hair net prior to entering the kitchen. The DM further reported a box of hair nets was kept on the table at the entrance of the kitchen.

On 02/29/12 at 8:50 AM an interview was conducted with NA #2. NA #2 stated that she knew not to go into the kitchen without a hair net. She reported she should have stood at the kitchen's door and asked the kitchen staff for the

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F 371	Continued From page 44 item that she needed. On 03/02/12 at 2:40 PM an interview was conducted with the Director of Nursing (DON). The DON stated that staff should know not to go into the kitchen without wearing a hair net as they had been given an in-service that covered this topic approximately six (6) months ago.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	*F-441* The facility will continue to 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. Resident's #12 and #52 had glucometer cleansed prior to nurse taking blood sugar. The medication drawer was immediately cleaned by the D.O.N. and contents were disposed of per facility policy. The D.O.N. in-serviced the nurse regarding the glucometer disinfection policy. All nursing staff was in-serviced on the facility policy for the glucose monitoring device.	

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F 441	Continued From page 45 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews facility staff failed to disinfect a glucometer for two (2) of five (5) residents observed for finger stick blood sugars. (Resident #12 and Resident #52). The findings are: A review of a facility policy titled "Blood Glucose Monitoring" dated 11/17/10 indicated "the monitor will be cleaned after each resident use with a bleach based product." 1. During an observation on 3/1/12 at 5:51 AM Licensed Nurse (LN) # 2 took a blood glucose monitor (glucometer) out of a drawer of a medication cart and placed it on top of the cart. She then took alcohol wipes and a lancet out of the cart and placed them next to the glucometer. She picked up the glucometer, alcohol wipes and lancet and took them into Resident # 12's room. She washed her hands with hand sanitizer, put on gloves and performed a finger stick blood sugar on Resident #12. She removed her gloves, disposed them in the trash with the used alcohol wipes, and walked out of the resident's room with	F 441	A QA Monitoring tool will be utilized by the D.O.N./designee to ensure compliance of disinfection of glucometer every shift/x2 weeks and then daily x4 weeks. Results of the audits will be reported to the monthly QA committee for the next two meetings or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program.	

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F 441	Continued From page 46 the glucometer and used lancet in her hand. She put the lancet into a sharps container on the medication cart and opened the drawer in the medication cart and placed the glucometer inside and closed it. She then opened a Medication Administration Notebook on top of the cart and moved the medication cart down the hallway to the next resident's room. During an interview on 3/1/12 at 5:57 AM LN #2 stated the glucometer was supposed to be cleaned with wipes containing a bleach solution (sani wipes) before or after each use and she had already cleaned the glucometer with a sani wipe earlier that morning. She further stated she would clean it before she used it on the next resident. During an observation on 3/1/12 at 5:58 AM LN #2 opened the medication cart and took out one pill for Resident #52 and placed it in a medicine cup on top of the medication cart. LN #2 took the glucometer out of the drawer in the medication cart and placed it on top of the cart. She then picked up alcohol wipes, a lancet, the medicine cup with the pill in it, glucometer, gloves and walked inside the doorway to Residents #52's room. During an interview on 3/1/12 at 6:01 AM LN #2 stated she was going to use the glucometer to check Resident #52's blood sugar and thought she had already cleaned it. During an observation on 3/1/12 at 6:02 AM LN #2 turned around and walked out of Resident #52's room, went back to the medication cart and cleaned the glucometer with a disposable wipe	F 441		

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BEYSTONE HEALTH & REHABILITATION	**80 BROWNSBERGER CIRCLE** **FLETCHER, NC 28732**

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F 441	Continued From page 47 containing bleach solution (sani-wipe). LN #2 then went back into Resident #52's room, performed a finger stick blood sugar, carried the glucometer to the medication cart and cleaned it with a sani-wipe and put it in the drawer in the medication cart. During a follow up interview on 3/1/12 at 6:14 AM LN #2 verified she did not clean the glucometer after she did the finger stick blood sugar on Resident #12. LN #2 stated she was going to use the glucometer when she went into Resident #52's room because she thought she had already cleaned it. She explained it was her usual procedure "to clean it before I use it." During an interview on 3/1/12 at 3:58 PM the Director of Nursing (DON) explained the glucometer should be cleaned after it's used to check a resident's finger stick blood sugar. She stated nursing staff should use the bleach wipes (sani wipes) to wipe it down and then they can put it back in the drawer of the medication cart.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the call bell system was functioning for one (1) of one (1) common shower room used by residents.	F 463	*F-463* The facility will continue to ensure the nurses' station is equipped to receive resident calls through a communication system from resident rooms, toilet, and bathing facilities. No facility residents were affected by the documented practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING ______ B. WING ______	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 48 The findings are: On 03/01/12 at 4:21 PM an observation of the common shower room used by residents revealed the emergency call bell system was inoperative. The shower room could be entered through two doors, one on the 200 hall and one on the 300 hall. When the call bell activation cord was pulled in the shower room, the lights above the two doors did not come on and the alarm did not sound at the nursing station. At that time, three unsuccessful attempts were made to activate the system. On 03/01/12 at 4:26 PM the Administrator was interviewed. He reported the Maintenance Director was out of the building at that time. He stated most residents showered in the bathrooms in their rooms and there were only three residents who used the common shower room. He stated he was not aware of any previous problems with this call bell, and he had asked the Maintenance Director to return to the building to repair it. He stated that in the meantime he had locked the two shower doors and posted signs not to use the shower. The Administrator stated he expected the facility call bell system to be checked routinely by the Maintenance Director as part of the preventive maintenance program, but he was not sure if it was. On 03/01/12 at 4:50 PM the Maintenance Director, who had returned to the facility, was interviewed. He stated he had repaired the shower call bell which had had a loose connection. He demonstrated the call bell was working by successfully activating the lights and	F 463	The shower room call bell system was repaired at the time of survey. The shower room was not accessible to any residents until the call bell system was fully functioning. An inspection of all other call light systems was completed, no further issues were identified. All staff inserviced on the procedure for reporting non-functioning equipment to the Maintenance Director. The Maintenance Director was inserviced by the Administrator on the facility's policy for checking call light system function through the preventative maintenance program. The Maintenance Director and designee will perform routine maintenance on all call light systems within the facility 2x/week for 2 weeks, then permanently weekly thereafter. Any issues will be corrected immediately. Compliance will be monitored by the monthly QA committee for the next two meetings or until resolved. Additional education/training will be provided for any issues identified.	

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F 463	Continued From page 49 alarm and then canceling them. He stated no one had reported to him that this call bell was inoperative. The Maintenance Director stated that none of the call bells in the facility were currently on a routine maintenance schedule, but that he intended to initiate routine checks of all call bells.	F 463	Continued compliance will be monitored through routine daily rounds, the facility's preventative maintenance and quality assurance programs. Additional education and monitoring will be initiated for any identified concerns.	
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that one (1) of five (5) employees was adequately trained in the facility's fire emergency procedures. The findings are: On 03/02/12 at 8:00 AM Laundry Aide #1 was observed in the facility laundry room. A fire extinguisher was observed mounted on the wall of the laundry room and a fire alarm pull station was observed just outside the laundry room door mounted on the hallway wall. Laundry Aide #1 was interviewed at that time. She stated she was a housekeeper who worked in the laundry room on weekends and usually one other day a week. She stated she had been hired approximately eight months ago. She was asked what she was trained to do if there were a fire in	F 518	***F-518*** The facility will continue to provide emergency procedure training to all employees upon hire and periodically review procedures with existing staff. No residents were involved in the documented practice. All facility staff was in-serviced on fire emergency procedures which includes hands on demonstration of how to use a fire extinguisher. The Maintenance Director will conduct random staff interviews regarding fire emergency procedures 3x/week for 3 weeks and then weekly x2 months. These will be documented on the "Emergency Fire Procedure QA" tool. Compliance will be monitored by the monthly QA committee for the next two meetings or until resolved.	

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F 518	Continued From page 50 the laundry and she stated she was not sure. She was asked how she would notify the facility of a fire in the laundry and she stated she would pull the fire alarm. She stated she was not aware where the nearest fire alarm pull station was, but when asked if she could find one, she exited the laundry room and pointed to the pull station in the hallway. Laundry Aide #1 was asked what else she might do if there were a fire in the laundry and she stated she would exit the building. She was asked if she knew where the nearest fire extinguisher was and she pointed to the wall mounted fire extinguisher in the laundry room. She stated she did not know how to use the fire extinguisher. Laundry Aide #1 was asked if she had been trained to use the extinguisher in a demonstration during her initial orientation and she stated she had not. She stated she had received written materials on fire safety during orientation that may have included information about fire extinguishers. On 03/02/12 at 8:20 AM the Maintenance Director and the Housekeeping Supervisor were interviewed together. They reported that Laundry Aide #1 worked in the laundry room on the weekends and usually one other day during the week and had been hired on 06/27/11. The Maintenance Director stated that he did annual fire safety training for all staff and for all new hires during orientation. He stated he conducted monthly fire drills. He stated that if a fire occurred in the laundry room, he would expect the laundry aide to follow the following procedure: shut off all equipment, activate the fire alarm at the pull station, use the phone to announce a Code Red (fire) in the laundry, attempt to use the fire extinguisher on the fire if possible, and if not	F 518	Additional education/training will be provided for any issues identified. Continued compliance will be monitored through random staff interviews, periodic drills, and quality assurance programs. Additional education and monitoring will be initiated for any identified concerns.	

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F 518	Continued From page 51 possible, exit and close the door of the laundry, and report to the nursing station for further instructions and to assist with any evacuation of residents deemed necessary. On 03/02/12 at 8:55 AM, a follow-up interview was conducted with the Maintenance Director. He stated he would expect all laundry aides, including Laundry Aide #1, to know the fire procedure for the laundry room as stated above. He stated the annual fire safety inservice and the orientation inservice were the same and included written material on how to use a fire extinguisher. However, he stated the inservice did not include a hands on demonstration of an extinguisher and it did not include special instructions for laundry aides such as shutting down the equipment during a fire. He provided written and signed documentation indicating Laundry Aide #1 had received fire safety instruction on 12/07/11. On 03/02/12 at 9:30 AM the Administrator was interviewed. He stated he expected all employees to know the fire safety procedures for the facility and for their specific work location in the facility such as the laundry.	F 518		