STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345385	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 4/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN ST LINCOLNTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 280	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 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 observation, staff and resident interview and record review, the facility failed to include one (1) of three (3) sampled residents in planning care related to a scheduled 4:00 AM daily bolus feeding.(Resident #5).

The findings are:

Resident #5 was admitted to the facility on 10/29/08 with diagnoses which included Cerebral Vascular Accident, Dysphagia and Dementia. The annual Minimum Data Set (MDS) dated 3/6/12 assessed Resident #5 understood others, was usually understood, had difficulty communicating some words or finishing thought but could finish words or thoughts if prompted or given time. The MDS assessed Resident #5 cognition as moderately impaired.

Review of monthly physician's orders dated 4/2/12 revealed Resident #5 was to receive a Low Concentrated Sweet Puree Diet with nectar thickened liquids in addition to one can of diabetic supplement by gastrostomy tube twice daily.

Review of the April 2012 Medication Administration Records revealed bolus tube feedings scheduled at 8:00 PM and 4:00 AM in addition to every four hours water flushes.

Interview with Resident #5 on 4/26/12 at 12:54 PM revealed staff awoke her at 4:00 AM for the bolus feeding. Resident #5 explained she was able to go back to sleep and was used to this routine. Resident #5 reported she was not involved in the decision of bolus feeding times and would prefer a later time if staff would allow. Resident #5 explained she would always ask the nurse what the time was and sometimes, she received the bolus feeding at 5:00 AM.

Interview with Licensed Nurse (LN) #2 LPN on 4/26/12 at 12:59 PM revealed Resident #5 could inform staff

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345385	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 4/28/2012

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CARDINAL HEALTHCARE AND REHAB	931 N ASPEN ST LINCOLNTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 280	Continued From Page 1 of needs and preferences. Telephone interview with Licensed Nurse (LN) #3 on 4/27/12 at 5:03 AM revealed she always awakened Resident #5 at 4:00 AM for the bolus feeding. LN #3 reported she awakened Resident #5 by patting her on the side. LN #3 reported Resident #5 never complained and always asked the time, then went back to sleep after the feeding. Interview with the Registered Dietitian (RD) on 4/27/12 at 10:05 AM revealed she set the scheduled times of feedings. The RD reported she did not know why the 8:00 PM feeding was scheduled since she usually scheduled tube fed residents at 12:00 AM. The RD explained the bolus feedings were scheduled not to interfere with meals in order to aid appetite. The RD reported she did not know why the 8:00 PM feeding was scheduled since she usually scheduled tube fed residents at 12:00 AM. The RD did not remember meeting with Resident #5 and announced she would call Resident #5's family member. The RD questioned the need to include the resident in the decision of time of feeding.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING _____ B. WING _____	04/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN ST LINCOLNTON, NC 28092

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility failed to obtain a reference check for a potential employee prior to hire for 1 of 5 employee records reviewed. The findings are: The facility's Abuse Prohibition Policy recorded in part that reference checks would be completed on potential employees prior to hire. Review of an employee pre-screening revealed that a dietary employee began employment on 4/12/12. The employees file included one reference check that was completed prior to hire. Two additional documents for reference checks recorded the new employees name and the names of personal references, but did not include any information regarding a reference; the additional references were incomplete. An interview with the dietary manager on 4/28/12 at 9:37 AM revealed that she completed one reference check for this employee by contacting a previous employer. The additional references provided by the employee were personal references, not employers. The dietary manager stated that the additional reference checks were	F 226	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Additional reference check was obtained on the dietary employee. 2. Facility Human Resources Coordinator reviewed all current employee files of newly hired employees in the last 3 months to ensure documentation of reference checks were present in the employees' personnel files. Reference checks were obtained on any current employees hired within the past 3 months who were identified as needing additional references. Facility Administrator re-educated all current facility department managers on the facility's policy and procedure for obtaining reference checks on potential employees.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susie H. Martin | TITLE: Administrator | (X6) DATE: 5/11/12

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.

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F 226	Continued From page 1 incomplete because she did not ask questions of the personal references since they were not employers. An interview on 4/28/12 at 9:38 AM with the administrator confirmed that two reference checks had not been completed prior to hire for this employee as per the facility's abuse prohibition policy. The administrator instructed the dietary manager that personal references could be used as a reference if pertinent questions had been asked to complete the reference check.	F 226	3. Facility Administrator/Human Resources Coordinator will conduct Quality Improvement (QI) monitoring of the facility's personnel files to ensure reference checks are obtained prior to hire using a sample size of 3. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, and then 1 x monthly for 9 months. 4. Facility Administrator/Human Resources Coordinator will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.	5-26-12
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, medical record and facility record reviews, the facility failed to secure a Foley catheter drainage bag and tubing to a resident's wheel chair to promote privacy for 1 of 3 sampled residents reviewed for Foley catheters. (Resident #19) Resident #19 was admitted to the facility in March 2012 from the hospital with a urinary tract infection. Review of the admission Minimum Data Set (MDS) dated 4/5/12, assessed Resident #19 with impaired short and long-term memory, severely impaired daily decision-making skills and	F 241	1. Resident #19 suffered no harm. Resident #19's foley catheter and drainage bag were secured and covered immediately using a privacy bag upon identification by facility staff. Resident #19 received new orders for a leg bag while out of bed daily to ensure resident's dignity.	

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F 241	Continued From page 2 independent with mobility using a wheel chair. Review of the medical record revealed a physician's order dated 4/12/12 for the use of a Foley catheter for Resident #19. A plan of care updated 4/12/12 for Resident #19 regarding the use of a Foley catheter recorded in part to assure the drainage bag is covered to maintain/promote privacy. Resident #19 was observed on 4/24/12 at 12:29 PM seated in her wheel chair and assisted into the main dining room by nursing assistant #5 (NA #5). As Resident #19 and NA #5 rounded the corner to the dining room, her catheter drainage bag and tubing were both observed dragging along the floor, for approximately 25 feet to the table where she was placed for her lunch meal. Urine was visible in the catheter bag and tubing. A privacy bag was attached underneath the wheel chair of Resident #19. On 4/24/12 at 1:12 PM, NA #5 stated in an interview that she assisted Resident #19 to the dining room from the Resident's room, but she did not notice that the Resident's catheter drainage bag or tubing were on the floor. NA #5 further stated that if she had noticed it, she would have repositioned the catheter bag and tubing back in the privacy bag. On 4/24/12 at 3:25 PM, Resident #19 was observed to self propel in her wheel chair. A Foley catheter drainage bag was observed in a privacy bag attached underneath the Resident's wheel chair. Approximately six inches of the catheter tubing was observed coming from the Resident's leg and hanging underneath the	F 241	2. Facility Director of Clinical Services reviewed all current residents with foley catheters to ensure that foley catheters and drainage bags were secured and covered using a privacy bag or a leg bag as applicable. Facility Director of Clinical Services/Nurse Manager re-educated all current nursing staff that foley catheters and drainage bags are to be secured and covered to ensure residents' dignity. 3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring to ensure foley catheters and drainage bags are covered to ensure residents' dignity using a sample size of 3. QI monitoring will be conducted 3 times weekly for 1 month, then 1 x weekly for 2 months, and then 1 time monthly for 9 months. 4. Facility Director of Clinical Services/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 241	Continued From page 3 Resident's wheel chair. Urine was visible in the catheter tubing. On 4/24/12 Resident #19 was observed continuously from 4:41 - 4:53 PM. Resident #19 was seated in wheel chair and observed to self propel from her room to the nurse's station, approximately 25 feet. The Resident's catheter drainage bag and tubing were observed dragging along the floor. Urine was visible in the catheter bag and tubing. A privacy bag was observed underneath the Resident's wheel chair. The Resident stopped to rest along the right side of the hallway in front of the nurse's station with staff present including the director of nursing (DON) and licensed nurse #7 (LN #7). At 4:50 PM, Resident #19 self propelled from the right side of the hallway to left side of the hallway with the catheter bag and tubing dragging the floor, approximately 2 feet. An interview on 4/27/12 at 10:02 AM with the DON revealed she expected staff to continue to monitor a resident with a catheter in place to make sure the catheter remains in a privacy bag. If a resident's catheter tubing comes out of the privacy bag, staff should monitor that and try to put it back. On 4/28/12 at 9:00 AM, interview with licensed nurse #7 (LN #7) revealed that staff were trained to maintain catheter bags and tubing in a privacy bag to protect the resident's privacy.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246		

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F 246	Continued From page 4 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide the correct dining table height to maintain independence in eating for one (1) of four (4) sampled residents (Resident #56). The findings are: Resident #56 was admitted with diagnoses which included Alzheimer's Disease. A Minimum Data Set (MDS) dated 12/6/11 assessed Resident #56 with short and long term memory problems with supervision and set up required for eating. The most recent MDS dated 2/28/12 assessed that Resident #56 required the physical assistance of one person with eating. Resident #56's care plan dated 3/8/12 listed interventions of provision of assistance with eating as necessary. Observation during the lunch meal on 4/24/12 from 12:06 PM to 12:58 PM revealed Resident #56 seated in a wheelchair at a dining table. The edge of the table was approximately three inches below Resident #56's shoulders. Resident #56 attempted unsuccessfully to reach a glass of water. Nursing Assistant (NA) #2 handed Resident #56 the glass. Resident #56 lowered the beverage to her lap to drink. Resident #56 reached up to the plate and independently ate the	F 246	1. Resident #56 suffered no harm. Resident #56's wheelchair seat was immediately raised upon identification to maintain independence with eating in the dining room. 2. Facility Director of Clinical Services reviewed all current residents to ensure that they were at the correct dining table height to maintain independence with eating in the dining room. Any current residents identified to be at an incorrect dining table height had adjustments made to chairs and/or tables, as applicable, to maintain independence with eating in the dining room. Facility Director of Clinical Services/Nurse Manager re-educated all current nursing staff to ensure they are aware of the correct dining table height for residents to maintain independence. 3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring to ensure residents are at the correct dining table height to maintain independence using a sample size of 6. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, then 1 x monthly for 9 months.	

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F 246	Continued From page 5 rest of the meal. Observation on 4/26/12 at 8:45 AM revealed Resident #56 used an over the bed table for the breakfast meal in her room. Resident #56 accessed all of the meal independently seated in her wheelchair with the table edge at waist height.. Observation on 4/26/12 at 12:23 PM revealed Resident #56 seated in a wheelchair at the dining table. The edge of the table was approximately three inches below Resident #56's shoulders. Resident #56 dropped peas and a dinner roll on her lap after reaching up to the plate. Interview with NA #2 on 4/26/12 at 12:25 PM revealed NA #2 assisted in the dining room for lunch and supper five days a week. NA #2 reported Resident #56 always sat at the same table in the same wheelchair. NA #2 explained she assisted Resident #56 with eating at times by handing items dropped on the lap and glassware since she could not reach everything. NA #2 reported Resident #56's wheelchair was low at the dining table. Upon observation of Resident #56 at the dining room table on 4/26/12 at 12:37 PM, the Director of Nursing (DON) stated Resident #56's wheelchair was too low at the table. The DON reported a referral for therapy related to positioning would be indicated. Interview with the Occupational Therapist (OT) on 4/26/12 at 12:47 PM revealed residents referred for positioning evaluations received wheelchair and table height assessments to ensure proper	F 246	4. Facility Director of Clinical Services/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 246	Continued From page 6 height to maintain independence with eating. The OT reported she received a referral related to Resident #56's transfer ability and leg weakness yesterday but had not received a referral for dining position.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and family interviews, and record review, the facility failed to provide an ongoing program of activities for a resident with speech, vision and hearing deficits related to the resident's preferences and interests which resulted in increased social isolation for one (1) of three (3) sampled residents. (Resident #5) The findings are: Resident #5 was admitted to the facility on 10/29/08 with diagnoses which included Cerebral Vascular Accident and Dementia. The annual Minimum Data Set (MDS) dated 3/6/12 assessed Resident #5 with adequate hearing, unclear speech and moderately impaired vision. The MDS assessed Resident #5 understood others, was usually understood, had difficulty communicating some words or finishing thought but could finish words or thoughts if prompted or	F 248	1. Resident #5 suffered no harm. Facility Activities Director completed a new Activity Interest Assessment on Resident #5 indicating current interests and preferences of resident. Activity Director is providing activities of choice for Resident #5 with regard to her speech, vision and hearing deficits. Resident #5's care plan was updated accordingly. 2. Facility Activities Director reviewed all current residents and completed a new Activity Interest Assessment for each one. Facility Activities Director also reviewed all current residents for speech, vision, and/or hearing deficits to ensure that appropriate activities of choice are offered. Facility Activities Director updated current residents' care plans as needed. Current residents will be reassessed quarterly, annually and/or as needed with changes in condition. Regional Director of Clinical Services re-educated Facility Activities Director on the facility policy and procedures for the Provision of Facility Activities, Activity Interest Assessments, and Activity Care Plans.	

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F 248	Continued From page 7 given time. The MDS assessed Resident #5 cognition as moderately impaired. The MDS listed the following activities as very important to Resident #5: have books, newspaper; magazines to read; listen to music; be around animals/pets; keep up with news; do things with groups of people; do favorite activities; go outside in good weather; and participate in religious practices. Review of the quarterly Social Services progress note dated 3/6/12 revealed Resident #5 was alert and oriented to person, place and time. The Social Worker documented Resident #5 preferred to do independent activities such as working on puzzles or reading a book. Review of Resident #5's activity care plan dated 3/15/12 revealed Resident #5's current interests were animals/pets, cards, games, listening to music, outdoors/walking, sitting, reading, spiritual/religious activity, talking/conversing and watching television. There were no goals, activity adaptations or interventions listed on the care plan. Review of the Activity Director's (AD) note dated 3/15/12 revealed Resident #5 preferred to do activities on her own and came to the dining room for lunch and supper for socialization and music. The AD documented Resident #5 liked to sit outside her door and watch people go up and down the hall. Observation on 4/24/12 from 12:08 PM to 12:38 PM during the lunch meal revealed staff and residents seated at the table did not engage Resident #5 in social conversation. Background music was provided. Resident #5 did not attempt	F 248	3. Facility Administrator/Director of Clinical Services will conduct QI monitoring, using Activity Interest Assessments, Activities Care Plans, Activities Calendar and Activities Participation Record to ensure activities programs are offered with regard to residents' interests and preferences and appropriate activities of choice are offered for residents with speech, vision and/or hearing deficits using a sample size of 6. Facility Administrator/Director of Clinical Services will conduct QI monitoring 3 x weekly for 1 month, then 1 x weekly for 2 months, and then 1 time monthly for 9 months. 4. Facility Administrator/Director of Clinical Services will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 248	Continued From page 8 to engage others in conversation. Resident #5 self propelled out of the dining room after she finished eating. Observation on 4/24/12 from 5:08 PM to 5:20 PM during the evening meal revealed staff and residents seated at the table did not engage Resident #5 in social conversation. Background music was provided. Observations on 4/25/12 at 8:20 AM, 8:45 AM and at 11:29 AM revealed Resident #5 seated in a wheelchair outside the door of her room watching staff and residents. Interview with Resident #5 on 4/25/12 at 9:07 AM revealed she felt a general sense of fear at times. Resident #5 was not able to specify the time, place or reason for this feeling of fright and explained she never told anyone. During the interview, Resident #5 required the surveyor to talk loudly into the right ear in order to hear. When presented with letters approximately two inches high, Resident #5 reported she could not see the letters. Observations on 4/26/12 at 8:11 AM, 9:34 AM, 10:09 AM, and 4:26 PM revealed Resident #5 seated in a wheelchair outside the door of her room watching staff and residents. When acknowledged by staff, Resident #5 smiled. Observation on 4/26/12 from 12:20 PM to 12:26 PM during the lunch meal revealed staff and other residents did not engage Resident #5 in social conversation. Resident #5 did not attempt to engage others in conversation. Background music was provided. Resident #5 self propelled	F 248		

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F 248	Continued From page 9 out of the dining room when she finished eating. Interview with Nursing Assistant (NA) #2 on 4/26/12 at 12:26 PM revealed Resident #5 came independently to the café one half hour early for meals. NA reported she did not know the reason for Resident # 5's early arrival. NA #2 reported Resident #5 was very hard of hearing and knew staff and remembered recent events. NA #2 reported she assisted residents in the dining room in the set up of meals but did not direct or engage in social activities. Interview with Licensed Nurse (LN) #2 on 4/26/12 at 12:59 PM revealed Resident #5 sat in the doorway of her room and watched people. LN #2 reported Resident #5 was cognitively intact. LN #2 explained this was Resident #5's usual routine and other than family members visiting regularly, there were no other activities. Observations on 4/26/12 at 4:26 PM revealed Resident #5 seated in a wheelchair outside the door of her room watching staff and residents. A second interview was conducted with Resident #5 on 4/27/12 at 9:08 AM. Resident #5 revealed she did not hear the music in the dining room or converse during meals. Resident #5 reported she did not enjoy group activities since she could only hear direct one to one conversation. Resident #5 reported she refused invitations to organized activities. Resident #5 revealed she watched staff and visitors during the day except for mealtimes. She explained staff were busy working and could not stop to talk with her and it caused her to feel "sad." Resident #5's eyes filled with tears. Resident #5 reported she did not	F 248		

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tell staff of her feelings since they were so busy.

Continued interview with Resident #5 revealed she can no longer do puzzles because she could not see well. Resident #5 explained she was not aware of any hearing adaptive devices such as earphones but might be interested to try them in order to hear books on tape or music.

Interview with NA #1 on 4/27/12 at 10:27 AM revealed Resident #5 refused to attend organized activities when invited. NA #1 explained Resident #5 was aware of staff identities and remembered things but NA #1 sometimes had trouble understanding her. NA #1 explained Resident #5 was very hard of hearing.

Interview with LN #6 on 4/27/12 at 10:50 AM revealed Resident #5 at times appear to be frowning and sad. LN #6 explained she would ask Resident #5 if anything was wrong and Resident #5 would ask her to call her son to come and visit.

Interview with the Activity Director (AD) at 3:46 PM on 4/27/12 revealed she did not realize Resident #5 could not hear music, did not socialize during meals and did not see well. The AD explained she received no complaints from Resident #5 about not hearing the music or lack of social engagement. The AD revealed she was not aware of Resident #5's poor vision and stated perhaps that was a reason Resident #5 no longer did puzzles. The AD reported Resident #5's family members visited regularly and they provided activities such as outside visits and conversation. The AD added Resident #5 also enjoyed the beauty shop weekly. The AD

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F 248	Continued From page 11 revealed Resident #5 refused to attend out of the room activities but liked to watch people go by. A telephone interview was conducted on 4/27/12 at 4:32 PM with Resident #5's family member. During this interview, the family member explained Resident #5 enjoyed social conversations with others who were able to "take the time and patience" to have the conversations. The family member reported Resident #5 did not like large groups because of her hearing deficits and she had difficulty hearing music in that setting. The family member explained Resident #5's family members came regularly to visit and provided social engagement.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide a behavior management plan related to combative behavior for one (1) of three (3) sampled residents who received psychoactive medications (Resident #66). The findings are: Resident #66 was admitted to the facility with diagnoses which included Alzheimer's Dementia,	F 250	1. Resident #66 suffered no harm. Facility MDS Director updated Resident # 66's behavior care plan to include successful approaches for managing those behaviors as indicated by the facility's interdisciplinary team. 2. Facility Social Services Director reviewed current residents with behaviors to ensure that their care plans indicated successful approaches for managing those behaviors as indicated by the facility's interdisciplinary team. Facility Social Services Director re-educated all current nursing staff and facility interdisciplinary team on facility's policy and procedure for behavior management and updating residents' care plans quarterly, annually and/or as needed with	

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F 250	Continued From page 12 Anxiety and Depression. The admission physician's orders for medication dated 3/13/12 included Clonazepam (anti-anxiety) 0.25 milligrams (mg.) twice daily and Seroquel (anti-psychotic) 1000 mg. twice daily. Review of Resident #66's care plan dated 3/13/12 revealed potential for side effects from psychotropic medication use listed as a problem with interventions which included monitoring resident mood, interactions with others and mental status. The care plan also listed a self care deficit as a problem with severely impaired decision making skill. Interventions included monitoring for overstimulation, increased frustration, restlessness, increase in behaviors or resistance to care in addition to provision of positive feedback and reassurance with task completion. Review of Resident #66's admission Minimum Data Set (MDS) dated 3/20/12 assessed Resident #66 with short and long term memory problems, moderately impaired decision making skills and no mood or behavior problems. The admission MDS also coded staff believed Resident #66 was capable of increased independence. Review of a physician's order dated 4/16/12 revealed an additional diagnosis of Dementia illness with behavior symptoms. Review of mental health notes dated 4/18/12 revealed there were no serious behavior issues reported by staff. Observation of Resident #66 on 4/24/12 at 11:01	F 250	changes in condition to indicate successful approaches. 3. Facility Administrator/Social Services Director will conduct QI monitoring of residents with behaviors to ensure that successful approaches for behavior management are indicated on the residents' care plans and that the facility interdisciplinary team is aware of those approaches and/or where to locate that information using a sample size of 6. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, and then 1 x monthly for 9 months. 4. Facility Administrator/Social Services Director will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 250	Continued From page 13 AM and 4:47 AM revealed she self propelled in a wheelchair in the hallway. Observation on 4/25/12 at 9:40 AM revealed Resident #66 sleeping. At 11:39 AM, Resident #66 was seated in a wheelchair in the hallway and smiling. Interview with Nursing Assistant (NA) #1 on 4/25/12 at 11:05 AM revealed Resident #66 became upset with care frequently. NA #1 explained Resident #66 would yell at staff and frequently refused assistance with showers and grooming. NA #1 explained she tried to figure out what would be best for Resident #66 by trying different approaches. NA #1 reported she did not receive specific information or direction related to Resident #66's behaviors but informally shared with other NAs what approaches were successful. Interview with Licensed Nurse (LN) #1 on 4/26/12 at 10:49 AM revealed she was aware of Resident #66's behaviors of yelling and resistance to care. LN #1 reported she was not aware Resident #66 scratched NA #6. LN #1 reported information related to Resident #66 was shared on an informal basis and by change of shift report. Interview with NA #6 on 4/26/12 at 10:50 AM revealed Resident #66 yelled and tried to strike out physically during showers and assistance with grooming. NA #6 explained Resident #66 scratched her during an attempt to trim fingernails. NA #6 explained she reported this behavior to the licensed nurses and learned to compliment Resident #66 on her appearance. NA #6 revealed she learned not to awaken Resident #66 and waited until later in the day to	F 250		

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F 250	Continued From page 14 offer assistance. NA #6 reported she learned of Resident #66's behaviors through informal discussions with other NAs. Interview with the Occupational Therapy Assistant (OTA) on 4/27/12 at 8:51 AM revealed Resident #66 received a discharge from therapy due to uncooperative behavior such as yelling and kicking at staff. The Director of Rehabilitation Therapy (DRT) was aware of this behavior and different approaches were tried without success. The OTA reported she was not aware of any of successful approaches in care for Resident #66. Interview with the Director of Rehabilitation Therapy (DRT) on 4/27/12 at 8:56 AM revealed Resident #66 was discharged from therapy after two weeks due to lack of participation due to combative behavior. The DRT explained Resident #66 kicked a physical therapist and received a therapy discharge. The DRT revealed she reported this behavior to nursing department during the daily morning meetings. Interview with the Social Worker (SW) on 4/27/12 at 11:09 AM revealed she heard of Resident #66's care and therapy refusals during the daily morning meetings shortly after Resident #66's admission. The SW explained she referred Resident #66 to mental health for medication review and did not inform the psychologist of Resident #56's refusals of care and combative behavior. The SW explained she did not arrange meetings with direct care staff to discuss approaches for care related to Resident #66's behavior but thought the nursing department conducted meetings.	F 250		

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F 250	Continued From page 15 Interview with the MDS Coordinator on 4/27/12 at 11:21 AM revealed the SW would assess Resident #66's behaviors. The MDS Coordinator explained she would not be involved in behavior assessments, discussion with direct care staff or behavior management. Interview with Director of Nursing (DON) on 4/27/12 at 12:04 PM revealed she was aware of Resident #66's refusal of care and explained staff shared information regarding resident behavior during the change of shift report. The DON reported she would refer behavior problems to the SW.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	1. Resident #5 suffered no harm. Facility MDS Director conducted assessments of resident #5's hearing, vision, speech and combative behavior using the Resident Assessment Instrument (RAI). Facility MDS Director completed and filed corrections for resident #66's comprehensive assessment on the Minimum Data Set (MDS) as well as completed a Care Area Assessments (CAA) as indicated. 2. Facility MDS Director reviewed all current residents' most recent comprehensive assessments to ensure their accuracy for hearing, vision, speech, and/or combative behaviors on the MDS. CAAs were completed as indicated by the MDS. Facility MDS Director completed and filed corrected comprehensive	

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F 272	Continued From page 16 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to accurately assess hearing, vision and combative behavior for one (1) of twenty-three (23) sampled residents (Resident #5). The findings are: Resident #5 was admitted to the facility with diagnoses which included Cerebral Vascular Accident, Diabetes and Dementia. The annual Minimum Data Set (MDS) dated 3/6/12 assessed Resident #5 with adequate hearing, unclear speech and moderately impaired vision with no corrective lenses. The MDS assessed Resident #5 understood others, was usually understood, had difficulty communicating some words or finishing thoughts but could finish words or thoughts if prompted or given time. The MDS	F 272	assessments as needed. Regional MDS Coordinator re-educated Facility MDS Coordinator on facility's policy and procedure for completion of residents' comprehensive assessments using the RAI to ensure accuracy for hearing, vision, speech and/or combative behaviors on the MDS; as well as completion of CAAs as indicated by the MDS.. 3. Facility Administrator Director of Clinical Services will conduct QI monitoring of residents' comprehensive assessments to ensure accuracy for hearing, vision, speech, and/or combative behaviors on the residents' MDS along with the completion of CAAs, as indicated, using a sample size of 6. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, then 1 x monthly for 9 months. 4. Facility Administrator/Director of Clinical Services will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 272	Continued From page 17 assessed Resident #5's cognition as moderately impaired. Review of a quarterly Social Services progress note dated 3/6/12 revealed Resident #5's hearing impairment required the speaker to increase volume. The Social Worker documented Resident #5's vision was adequate with glasses/contacts. Review of the Care Area Assessment (CAA) for visual function dated 3/13/12 revealed Resident #5 reported inability to see fine print. Resident #5's diagnoses included macular degeneration, diabetic retinopathy and decreased visual acuity with routine eye evaluations. Review of the CAA for communication dated 3/13/12 revealed Resident #5 had no hearing impairment. The assessment documented Resident #5 communicated with unclear speech with the ability to make needs known. Interview with Resident #5 on 4/25/12 at 9:07 AM revealed she was very hard of hearing with poor vision. During the interview, Resident #5 required the speaker to talk loudly into the right ear in order for Resident #5 to hear. When presented with letters approximately two inches high, Resident #5 reported she could not see the letters. Resident #5 did not wear glasses. Interview with Nursing Assistant (NA) #2 on 4/26/12 at 12:26 PM revealed Resident #5 was very hard of hearing and could understand the surroundings and recognized people. Interview with Licensed Nurse (LN) #2 LPN on	F 272		

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F 272	Continued From page 18 4/26/12 at 12:59 PM revealed Resident #5 was cognitively intact and very hard of hearing. LN #2 explained she thought Resident #5's vision was normal but did not know for certain. Interview with the Activity Director (AD) at 3:46 PM on 4/27/12 revealed she did not realize Resident #5 could not hear the dining room music and did not see well. The AD revealed she was not aware of Resident #5's poor vision and stated perhaps that was a reason Resident #5 no longer did puzzles. Interview with the MDS Coordinator on 4/27/12 at 4:09 PM revealed Resident #5 was hard of hearing and the MDS assessment of adequate hearing was not accurate. The MDS coordinator reported the social worker assessed hearing and vision deficits. The MDS Coordinator reported she was not aware of the extent of Resident #5's vision deficits. Interview with the Social Worker (SW) on 4/27/12 at 4:23 PM revealed the assessment of Resident #5's hearing was not accurate. The SW explained she did not know the extent of Resident #5's vision deficits. The SW explained she was in the process of learning how to perform vision assessments.	F 272		
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 plan for each resident that includes measurable	F 279	1. Residents #5, #19, #47, #66, and #67 suffered no harm. Facility MDS Director developed comprehensive care plans for Residents #5, #19, #47, #66 and #67 to include interventions with measurable goals as applicable for activities, poor vision, and thickened liquids.	

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F 279	Continued From page 19 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 observations, staff and resident interviews, and record review, the facility failed to develop comprehensive care plans which included interventions for activities, poor vision, thickened liquids, and measurable goals for five (5) of twenty-three (23) sampled residents (Residents #5, #19, #47, #66 and #67). The findings are: 1. Review of Resident #5's annual Minimum Data Set (MDS) dated 3/6/12 and care plan dated 3/15/12 revealed the following: a) The annual MDS dated 3/6/12 listed Resident #5 received a mechanically altered diet and received 26% to 50% of calories from a feeding tube. The MDS assessed Resident #5 with a swallowing disorder.	F 279	2. Facility MDS Director reviewed all current residents' care plans to ensure they included interventions with measurable goals for activities, poor vision and thickened liquids as applicable. Regional MDS Director re-educated the Facility MDS Director on the facility policy and procedure for development of comprehensive care plans for residents to include interventions with measurable goals. MDS Director then re-educated the current facility interdisciplinary team on the facility policy and procedure for development of comprehensive care plans for residents to include interventions with measurable goals. 3. Facility MDS Director/Director of Clinical Services will conduct QI monitoring of residents' care plans to ensure they include interventions with measurable goals for activities, poor vision and thickened liquids, as applicable using a sample size of 6. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, and then 1 x monthly for 9 months. 4. Facility MDS Director/Director of Clinical Services will report results of QI monitoring to the RM/QI Committee for continued compliance and/or revision.	5-26-12

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F 279	Continued From page 20 Review of the Care Area Assessment (CAA) dated 3/13/12 revealed Resident #5 was not able to sustain nutrition without tube feeding and received a pureed diet with nectar thick liquids. Review of Resident #5's care plan dated 3/15/12 revealed the pureed diet and thickened liquids were not included on the care plan. Interview with the Registered Dietician on 4/27/12 at 10:52 AM revealed she relied on the MDS Coordinator to list interventions of diet and thickened liquids on Resident #5's care plan. Interview with the MDS Coordinator on 4/27/12 at 4:09 PM on 4/27/12 revealed she did not include the pureed diet or thickened liquids. The MDS Coordinator reported the pureed diet and thickened liquids should have been included in the care plan. b) The annual MDS dated 3/6/12 assessed Resident #5 with moderately impaired vision with no corrective lenses. Review of a quarterly Social Services progress note dated 3/6/12 revealed the Social Worker (SW) documented Resident #5's vision was adequate with glasses/contacts. Review of Resident #5's care plan dated 3/22/12 revealed there were no interventions related to a vision deficit. Review of the Care Area Assessment dated 3/13/12 revealed Resident #5 was unable to see small print and would not be care planned. Interview with Resident #5 on 4/25/12 at 9:07 AM	F 279		

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F 279	Continued From page 21 revealed she could not see letters approximately two inches high. Resident #5 did not wear glasses. Interview with the MDS Coordinator on 4/27/12 at 4:09 PM revealed Resident #5's vision deficit was not included on the care plan. The MDS Coordinator did not provide a reason for the omission but the SW would develop the care plan. Interview with the SW on 4/27/12 at 4:23 PM revealed she did not know the extent of Resident #5's vision deficits. c) The following activities listed on the MDS dated 3/6/12 were very important to Resident #5: have books and newspapers to read; listen to music; be around animals/pets; keep up with news; do things with groups of people; do favorite activities; go outside in good weather; and participate in religious practices Review of Resident #5's activity care plan dated 3/15/12 revealed Resident #5's current interests were animals/pets, cards, games, listening to music, outdoors/walking, sitting, reading, spiritual/religious activity, talking/conversing and watching television. There were no goals, activity adaptations or intervention listed on the care plan. Interview with the Activity Director on 4/27/12 at 3:46 PM revealed she did not indicate interventions or a goal for Resident #5's activities. The Activity Director was not able to provide a reason for the omission of interventions or goals. 2. Resident #66's admission Minimum Data Set	F 279		

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F 279	Continued From page 22 (MDS) dated 3/20/12 assessed Resident #66 required the extensive assistance of one person for transfers, dressing and personal hygiene. Review of Resident #66's care plan dated 3/13/12 revealed a self care deficit with inability to complete a self care task independently listed as a problem. The documented goal of: "will maintain/improve level of participation in ADLs (Activities of Daily Living) by next review of 6/13/12" was not measurable in terms of definition of participation. During an interview on 4/28/12 at 9:11 AM, the MDS Coordinator on 4/28/12 at 9:11 AM reported Resident #66's goal for the self care deficit was not measurable. 3. Resident #67's quarterly Minimum Data Set (MDS) dated 1/24/12 revealed Resident #67 required the extensive assistance of one person with dressing and personal hygiene. Review of Resident #67's care plan dated 4/26/12 revealed a self care deficit with inability to complete a self care task independently listed as a problem. The documented goal of: "will maintain/improve level of participation in ADLs (Activities of Daily Living) by next review of 7/26/12" was not measurable in definition of participation.. During an interview on 4/28/12 at 9:15 AM, the MDS Coordinator on 4/28/12 at 9:11 AM reported Resident #67's goal for the self care deficit was not measurable. 4. Resident #19 was admitted to the facility in	F 279		

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F 279	Continued From page 23 March 2012 with a history of falls prior to admission. Diagnoses included in part, vascular mixed-type dementia with delirium, agitation and behaviors. Review of the admission Minimum Data Set (MDS) dated 4/5/12, assessed Resident #19 with impaired short and long-term memory, severely impaired daily decision-making skills and one fall since admission. The care plan, last updated 4/16/12, identified Resident #19 had a potential for falls related to wandering and use of anti-anxiety/anti-depressant medications and confusion. The goal was recorded as "Will have no serious injury from falls by next review; fall preventative measures will remain in place." The goal did not define a serious injury. On 4/28/12 at 11:53 AM, the MDS Coordinator was interviewed and stated that the care plan goal for falls for Resident #19 was incomplete. The goal should have included how the serious injury would be measured to include fractures or a concussion or an injury that required a hospitalization and measured by completing of neurological checks. The MDS coordinator said the additional information was not added because the care plan was done in a hurry. 5. Resident #47 was admitted to the facility in June 2010. Diagnoses included failure to thrive and mental disorder with agitation. A significant change minimum data set (MDS) dated 2/7/12, assessed Resident #47 with impaired memory, severely impaired daily	F 279		

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F 279	Continued From page 24 decision-making skills and receiving non-surgical dressings, ointments and medication for her skin. A care plan dated April 2012 identified Resident #47 with skin tears to her elbows. The goal included that the area would be healed and remain free of infection. The goal did not include how the facility would determine that the skin tear was healed or free from infection. On 4/28/12 at 11:50 AM, the MDS Coordinator confirmed in interview that the goal for skin impairment for Resident #47's care plan was not complete because the care plan was done in a hurry. She stated the goal should have recorded that the skin tear would be monitored to make sure there were no signs of infection to include the absence of a fever, redness, or other signs or symptoms of an infection.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, family and resident interviews the facility failed to ensure that a right arm trough was attached to the wheelchair for one(1) of three (3) sampled residents. (Resident #91)	F 309	1. Resident # 91 suffered no harm. Resident #91's arm trough was immediately placed on the wheelchair. Resident #91's care plan and resident's profile were updated to indicate usage of the arm trough on the wheelchair. 2. Facility Director of Clinical Services reviewed all current facility residents to ensure those residents with physician's orders for arm troughs have them in place as ordered. Facility Director of Clinical Services re-	

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F 309	Continued From page 25 Findings are: Resident #91 was admitted in March 2012 with diagnoses of Cerebral Vascular Accident, Right Hemiplegia, Vascular Dementia and Hypertension. A Minimum Data Set (MDS) admission assessment dated 3/15/12 documented Resident # 91 with no cognitive impairment and requiring extensive assistance with dressing. The MDS also documented impaired upper and lower extremity range of motion (ROM). A review of Resident #91's medical record revealed an occupational therapy note dated 3/16/12 documenting Resident #91 being issued a right (R) arm trough. An occupational therapy note dated 4/9/12 documented the importance of wearing the arm trough to decrease swelling and pain. On 4/24/12 at 10:15 AM, 12:35 PM, 3:28 PM, 4:00 PM and 6:00 PM Resident #91 was observed in his wheelchair without an arm trough attached on his wheelchair. His (R) arm was flaccid " limp " and lying in his lap between his legs and his (R) hand was swollen. During an interview with the occupational therapist (OT) on 4/26/12 at 9:37 AM, the OT explained that Resident #91 has an arm trough that should be applied at all times when he is in his wheelchair. The OT further revealed that the arm trough was recommended by therapy because Resident #91's (R) arm was flaccid and needed to be elevated to decrease swelling and	F 309	educated all current nursing staff to ensure arm troughs are placed as indicated per the physician's orders and that the information is indicated on the resident's profile/Kardex as well as updated on the resident's care plan. 3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring of arm troughs to ensure that they are in place for residents per physician's orders using a sample size of 3. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, and then 1 x monthly for 9 months. 4. Facility Director of Clinical Services/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 309	Continued From page 26 reduce pain. The OT also stated that the arm trough decreased the risk of injury to Resident #91's (R) arm by keeping it secured. During an interview with the Director of Rehabilitation on 4/26/12 at 9:57 AM, the Director of Rehabilitation explained that it was the responsibility of the nursing staff to attach the arm trough to the wheelchair of Resident #91. The Director of Rehabilitation further explained that the nursing staff had been educated on how, when and why to attach the arm trough to Resident #91's wheelchair. During an interview with NA #5 on 4/26/12 at 10:04 AM, NA #5 confirmed that it was her responsibility to attach the arm trough. During an interview with LN #7 on 4/26/12 at 10:09 AM, LN #7 stated that it is the NA's responsibility to attach the arm trough and ensure that it is on the wheelchair when the resident is in the wheelchair. During an interview with the Director of Nursing (DON) on 4/26/12 at 10:16 AM she explained that she would have expected the NA to attach the arm trough to the wheelchair whenever Resident #91was in his wheelchair.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	1. Resident #19 suffered no harm. Resident #19 was provided catheter care using clean wipes. Resident #19's catheter tubing and drainage bag were in a privacy bag.	

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F 315	Continued From page 27 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to use a clean wipe while providing catheter care and failed to position catheter tubing and drainage bag from view for one (1) of three (3) sampled residents. (Resident #19) Findings are: Review of the facility policy titled "Catheter Care" revised in June 2008, revealed the following information: to minimize the risk of bladder infection that a clean washcloth should be used to cleanse the perineum and the catheter tubing. Resident #19 was readmitted on 3/29/12 with diagnoses of Urinary Tract Infection (UTI); Agitation and Mixed Dementia with Delirium. A Minimum Data Set (MDS) admission assessment dated 4/5/12 noted resident #19 with impaired short and long term memory and requiring extensive assistance with toileting and personal hygiene. A review of the medical record revealed a physician order dated 4/12/12 for an indwelling catheter until culture and sensitivity are negative secondary to Methicillin-Resistant Staphylococcus Aureus (MRSA).	F 315	2. Facility Director of Clinical Services reviewed all current residents to ensure that any with foley catheters had their catheter tubing and drainage bag in a privacy bag. Facility Director of Clinical Services/Nurse Manager re-educated all current nursing staff on maintaining the residents' catheters and drainage bags in a privacy bag as well as the facility's policy and procedure for provision of catheter care. Facility Director of Clinical Services/Nurse Manager completed competencies for catheter care with all current nursing staff; and catheter care competencies will be completed annually and as needed. 3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring of foley catheters to ensure that the tubing and drainage bags are in a privacy bag using a sample size of 3. Facility Director of Clinical Services/Nurse Manager will also conduct QI monitoring on all shifts on the provision of catheter care for residents using a	

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F 315	Continued From page 28 A plan of care dated 4/12/12 documented an intervention for indwelling catheter care every shift as per facility policy. Observations on 4/26/12 at 1:20 PM revealed Nursing Assistant (NA) #3 entered Resident #19's room to perform catheter care. During catheter care NA #3 wiped down the center of the perineum from front to back with a disposable wipe. NA #3 used the same disposable wipe and wiped from the urethral/catheter juncture down the catheter tubing. During an interview with NA #3 on 4/26/12 at 1:38 PM, she stated that normally she would have used a different disposable wipe to wash the catheter and could not explain why she did not while providing catheter care for Resident #19. During an interview with the Director of Nursing (DON) on 4/27/12 at 11:42 AM, the DON stated that her expectation would have been for the NA to have discarded the wipe after cleansing down the center of the perineum and to use a clean wipe to wash the catheter tubing. 2. The facility's "Catheter Care" policy revised June 2008 recorded in part to position/anchor the catheter and drainage bag below the level of the resident's bladder to facilitate the flow of urine; position/anchor drainage bag from view or cover with a privacy bag. Resident #19 was admitted to the facility in March 2012 from the hospital with antibiotic therapy for a urinary tract infection (UTI). Diagnoses included in part, vascular mixed-type dementia with	F 315	sample size of 6 (2 on 7-3 shift, 2 on 3-11 shift, and 2 on 11-7 shift). QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months and then 1 x monthly for 9 months. 4. Facility Director of Clinical Services/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 315	Continued From page 29	F 315		

delirium, agitation and Foley catheter due to MRSA in urine and behaviors.

Review of the admission Minimum Data Set (MDS) dated 4/5/12, assessed Resident #19 with impaired short and long-term memory, severely impaired daily decision-making skills and displaying signs of physical and verbal abuse toward staff and others. The MDS also assessed Resident #19 as independent with mobility using a wheel chair.

Review of the medical record for Resident #19 revealed a physician's order dated 4/12/12 for antibiotic therapy, Macrodantin 100 mg every 8 hours for 7 days for a UTI.

A plan of care updated 4/12/12 for Resident #19 regarding the use of a Foley catheter recorded in part to monitor the tubing to maintain free of obstruction, secure catheter tubing, maintain drainage bag below bladder level, and avoid tension.

Resident #19 was observed on 4/24/12 at 12:29 PM seated in her wheel chair and assisted into the main dining room by nursing assistant #5 (NA #5). As Resident #19 and NA #5 rounded the corner to the dining room, her catheter drainage bag and tubing were both observed dragging along the floor, for approximately 25 feet to the table where she was placed for her lunch meal. A privacy bag was attached underneath the wheel chair of Resident #19. At 12:35 PM the nurse consultant confirmed that Resident #19 had a Foley catheter and that the catheter should be contained in a privacy bag off the floor. The nurse consultant was observed to secure the catheter

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drainage bag in the privacy bag underneath the Resident's wheel chair.

On 4/24/12 at 1:12 PM, NA #5 stated in an interview that she assisted Resident #19 to the dining room from the Resident's room, but did not notice that the Resident's catheter drainage bag or tubing were on the floor. NA #5 further stated that if she had noticed it, she would have repositioned the catheter drainage bag and tubing back in the privacy bag and off the floor.

On 4/24/12 Resident #19 was observed continuously from 4:41 - 4:53 PM. Resident #19 was seated in wheel chair and observed to self propel from her room to the nurse's station, approximately 25 feet. The Resident's catheter drainage bag and tubing were both observed dragging along the floor. A privacy bag was observed underneath the Resident's wheel chair. The Resident stopped to rest along the right side of the hallway in front of the nurse's station. At 4:50 PM, Resident #19 self propelled from the right side of hallway to left side of the hallway with the catheter drainage bag and tubing dragging floor, approximately 2 feet.

On 4/24/12 at 4:53 PM, the nurse consultant was observed to reposition the Resident's catheter drainage bag and tubing back in to the privacy bag.

On 4/24/12 at 5:52 PM, the director of nursing (DON) stated in an interview that the catheter drainage bag for Resident #19 was changed to a catheter with a leg bag because Resident #19 was observed with her catheter tubing on the floor.

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F 315	Continued From page 31 A follow up interview on 4/27/12 at 10:02 AM with the DON revealed she expected staff to continue to monitor a resident with a catheter in place to make sure the catheter remains in a privacy bag and the catheter strap remains in place to keep the catheter from being pulled. If a resident's catheter tubing comes out of the privacy bag, staff should monitor that and try to put it back. She also stated that a catheter drainage bag and tubing dragging the floor could increase the risk of infection for the resident. On 4/28/12 at 9:00 AM, interview with licensed nurse #7 (LN #7) whose duties included coordinating the facility's infection control program revealed that staff were trained to maintain the catheter in a privacy bag to prevent bacteria from getting on the catheter tubing and causing an infection for the resident.	F 315		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to provide thickened liquids between meals for one (1) of three (3) sampled residents with physician ordered thickened liquids (Resident #5). The findings are:	F 327	1. Resident #5 suffered no harm. Resident # 5 receives thickened liquids as ordered on meal trays and between meals 3 times daily. 2. Facility Director of Clinical Services reviewed current resident to ensure that those with physician's orders for thickened liquids receive them as ordered on meal trays and between meals 3 times daily. Facility Director of Clinical Services/Nurse Manager re-educated all current nursing staff to ensure that	

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F 327	Continued From page 32 Resident #5 was admitted to the facility with diagnoses which included Cerebral Vascular Accident, Diabetes, Dysphagia and Dementia. The annual Minimum Data Set (MDS) dated 3/6/12 listed Resident #5 received a mechanically altered diet and received 26% to 50% of calories from a feeding tube. The MDS assessed Resident #5 with a swallowing disorder. Review of Resident #5's laboratory results dated 3/12/12 revealed an elevated Blood Urea Nitrogen (BUN) level of 30 (reference range of 5 to 25) and a BUN to Creatinine ratio of 33 (reference range of 6.0 to 25.0). (A BUN to Creatinine ratio is used to check for dehydration. Dehydration causes the BUN level to rise more than creatinine levels.) Review of Resident #5's care plan dated 3/15/12 revealed nutrition and tube feeding listed as a problem with intervention which included water via tube, provision of tube feeding and dietary consult as needed. There were no interventions listed related to provision of thickened liquids. Review of monthly physician's orders dated 4/2/12 revealed Resident #5 was to receive nectar thickened liquids. Water flushes of 200 cc. were to be given every four hours in addition to one can of diabetic supplement by gastrostomy tube twice daily. Thirty milliliters (ml) of water were to be given before and after each medication pass scheduled at 10:00 AM and 6:00 PM.. Review of a dietary consult dated 4/11/12 revealed Resident #5's fluid intake at meals was less than 60 cc. and tube feeding provided 59%	F 327	residents with physician's orders for thickened liquids receive them as ordered on meal trays and between meals 3 times daily. 3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring to ensure that residents with physician's orders for thickened liquids receive them as ordered on meal trays and between meals 3 times daily using a sample size of 6. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months and then 1 x monthly for 9 months. 4. Facility Director of Clinical Services/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 327	Continued From page 33 of nutritional intake. The dietician documented a meeting with the nursing staff to review fluid adequacy with flushes that day. Observation on 4/26/12 at 8:11 AM revealed Resident #5 received a pureed breakfast meal with thickened juice and thickened milk. Resident #5 consumed 50% of the milk and 0% of the juice. After Nursing Assistant (NA) #1 removed the breakfast tray, there were no thickened liquids available for Resident #5. Observation on 4/26/12 at 10:06 AM revealed Licensed Nurse (LN) #2 administered Resident #5's medications via tube in addition to 120 cc. of water. LN #2 did not offer Resident #5 anything by mouth. Interview with LN #2 on 4/26/12 at 10:09 AM revealed Resident #5 received all medications and hydration via tube except for the thickened liquids on the meal trays. LN #2 reported Resident #5 received thickened liquids between meals from the NAs. Observation of the morning hydration pass on 4/26/12 revealed Resident #5 was not offered thickened liquids by Nursing Assistant (NA) #3. During the lunch meal on 4/26/12, Resident #5 consumed 100% of nectar thickened milk and 25 % of thickened water. Interview with Resident #5 on 4/26/12 at 12:54 PM revealed she did not receive thickened liquids between meals. Resident #5 explained she did not request or like thickened fluids but sometimes felt thirsty. Observation during this interview revealed there were no thickened liquids available	F 327		

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F 327	Continued From page 34 for Resident #5 to obtain independently. Observation of the afternoon hydration pass on 4/26/12 revealed Resident #5 was not offered thickened liquids by NA #3. Interview with NA #3 on 4/26/12 at 2:48 PM revealed she did not offer Resident #5 thickened fluids during the morning and afternoon hydration pass that day (4/26/12) because she thought the Licensed Nurses gave Resident #5 fluids during the medication administration. Interview with the Registered Dietitian (RD) on 4/27/12 at 9:50AM revealed she calculated Resident #5's hydration requirement and would conservatively estimate the amount of fluids between meals. The RD reported she increased the water flush amount in order to ensure adequate hydration since Resident #5's fluid consumption was less than 60cc a meal. The RD revealed thickened fluids should be offered between meals. Interview with NA #1 on 4/27/12 at 10:27 AM revealed Resident #5 received all of her thickened liquids on the meal trays. NA #1 reported Resident #5 received thickened liquids from the Licensed Nurses during the medication pass. Interview with LN #6 on 4/27/12 at 10:45 AM revealed Resident #5 should be offered thickened liquids at meals and from the NAs between meals. LN #6 reported she did not offer Resident #5 thickened liquids during the medication pass. Interview with the Director of Nursing on 4/27/12	F 327		

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F 327	Continued From page 35 at 12:15 PM revealed she expected nursing assistants and licensed staff to offer fluids between meals during the hydration pass and with medications.	F 327		
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 observation, resident and staff interview, and record review, the facility failed to serve a pureed diet to one (1) of three (3) sampled residents with physician ordered pureed diets (Resident #5). The findings are: Resident #5 was admitted to the facility with diagnoses which included Cerebral Vascular Accident, Diabetes, Dysphagia and Dementia. The annual Minimum Data Set (MDS) dated 3/6/12 listed Resident #5 received a mechanically altered diet and received 26 percent to 50 percent of calories from a feeding tube. The MDS assessed Resident #5 with a swallowing disorder. Review of monthly physician's orders dated 4/2/12 revealed Resident #5 was to receive a Low Concentrated Sweet (LCS) pureed Diet with nectar thickened liquids in addition to one can of diabetic supplement by gastrostomy tube twice daily. Review of the therapeutic spreadsheet for the	F 367	1. Resident # 5 suffered no harm. Resident # 5's diet order was updated to include a pureed banana on breakfast tray daily. Resident #5's cereal at breakfast was discontinued. 2. Facility Dietary Manager reviewed all current residents' diet orders to ensure all food items and special requests were consistent with their diets as ordered. Registered Dietician re-educated all dietary staff on ensuring that food items served to residents on meal trays are consistent with residents' diets as ordered. 3. Facility Administrator/Dietary Manager will conduct QI monitoring of residents' meal trays to ensure that food items and special requests served are consistent with the residents' diets as ordered using a sample size of 6. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, and then 1 x monthly for 9 months.	

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F 367	Continued From page 36 breakfast meal of 4/26/12 revealed residents on a pureed diet were to receive the following items: juice, pureed hot cereal, pureed sausage gravy, pureed biscuit, milk and coffee or hot tea. Review of the dietary slip on Resident #5's breakfast tray on 4/26/12 revealed a LCS Pureed diet with nectar thick beverages was to be served. Special request items of cereal and banana were listed on the dietary slip. Observation of the breakfast meal on 4/26/12 at 8:39 AM revealed Resident #5 received pureed biscuit, pureed sausage gravy, oatmeal with nectar thick milk and nectar thick cranberry juice. A bowl of dry crisped cereal and an unpeeled banana were also served to Resident #5. Resident #5 removed the banana from the breakfast tray and did not eat the crisped rice cereal. Nursing Assistant (NA) #1 removed the meal tray at 8:55 AM. Interview with Resident #5 on 4/26/12 at 4:26 PM revealed she received a banana every morning. Resident #5 explained she usually ate the banana before bedtime. The banana was at the bedside. Review of the therapeutic diet spreadsheet for the breakfast meal of 4/27/12 indicated residents on a pureed diet were to receive juice, pureed hot cereal, pureed egg, pureed bread, and coffee or hot tea. Observation of the breakfast meal on 4/27/12 at 8:46 AM revealed Resident #5 received pureed eggs, pureed oatmeal, pureed bread, nectar thick orange juice and nectar thick milk. A bowl of dry cornflakes was also served to Resident #5. Upon	F 367	4. Facility Administrator/Dietary Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 367	Continued From page 37 receipt of the breakfast meal, Resident #5 stated she would not eat the cornflakes because the cornflakes hurt her throat. Interview with the Cook on 4/27/12 at 9:22 AM revealed she plated the pureed meal. The cook explained dietary aides added special request items to the tray using the dietary slips as a guide. The cook explained that a banana should have been on Resident #5's breakfast meal tray. Interview with Dietary Aide #3 on 4/27/12 at 9:28 AM revealed she placed cold cereal onto Resident #5's breakfast tray every morning. She used the resident's dietary slip as a guide. Interview with Dietary Aide #2 on 4/27/12 at 9:30 AM revealed she placed an unpeeled banana on Resident #5's breakfast tray every morning. She explained she omitted the banana this morning by mistake. Dietary Aide #2 stated that she used the resident's dietary slip as a guide. She explained she knew Resident #5 liked crisped rice cereal better than the cornflakes because the cornflakes always came back uneaten. Interview with the Dietary Manager on 4/27/12 at 9:36 AM revealed nursing staff should mash the banana for Resident #5 upon tray delivery and pour the thickened milk onto the dry cereal. The Dietary Manager reported the dry cereal had never been pureed and there was no guidance on the therapeutic spread sheet for serving dry cold cereal to residents on a pureed diet. Interview with the Registered Dietitian on 4/27/12 at 9:50 AM revealed residents on a pureed diet were not to receive an unpeeled banana and dry	F 367		

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F 367	Continued From page 38 cereal as part of the breakfast meal. The RD reported the available guidance for kitchen staff did not include methods of serving cold cereal to residents on a pureed diet and bananas should be mashed.	F 367		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to monitor a dairy product for signs of expiration prior to serving to a resident (Resident #68), label a dairy product with the date of opening and remove out dated dairy products from refrigeration. The findings are: The facility policy, Sanitation, revised June 2009, recorded in part "Follow expiration date for all packaged goods." On 4/24/12 at 9:49 AM, during the kitchen tour, two unopened 32 ounce containers of plain cultured yogurt were observed stored on the shelf in the walk-in refrigerator. Each container of	F 371	1. Resident #68 suffered no harm. Physician was notified and no new orders were received for Resident #68. Facility Dietary Manager immediately discarded expired yogurt in the facility kitchen, upon identification. 2. Facility Dietary Manager inspected all dairy products in the kitchen for expiration and date of opening, if already opened. All expired dairy products and opened, undated dairy products were discarded by the Facility Dietary Manager. Registered Dietician re-educated all current dietary staff on dating dairy products upon opening along with discarding any expired dairy products and/or any opened, undated dairy products in the facility kitchen. 3. Facility Administrator/Dietary Manager will conduct QI monitoring of dairy products in the kitchen to ensure that they are dated upon opening and that they	

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F 371	Continued From page 39 yogurt bore the manufacturer expiration date stamp of 4/16/12. The dietary manager stated during the observation that she conducted daily monitoring of storage areas to include the walk-in refrigerator to observe for any expired items. She further stated she had not monitored the walk-in refrigerator that morning (4/24/12), but that the yogurt had been missed during her observations for the prior week. On 4/24/12 at 9:59 AM, the reach-in refrigerator was observed with one 32 ounce container of plain cultured yogurt with a manufacturer's expiration date stamp of 4/16/12. The container had been opened and approximately one cup of yogurt remained. There was no date of opening documented on the container. The interior sides of the container were observed with a fuzzy, hair-like growth and the yogurt was odorous. The dietary manager stated that Resident #68 received two tablespoons of plain yogurt daily per request. She confirmed that Resident #68 received yogurt that morning (4/24/12) with breakfast which was served from the opened container of yogurt. She also stated that staff should have recorded the date of opening on the yogurt, monitored products for signs of expiration prior to use and discarded food items once expired. On 4/24/12 at 10:00 AM an interview with dietary aide #1 revealed she plated plain yogurt for Resident #68 that morning (4/24/12) and the yogurt was taken from the opened container of yogurt, not dated with a date of opening, in the reach-in refrigerator. Dietary aide #1 stated she did not notice that the yogurt was expired neither did she notice any signs of expiration.	F 371	are discarded upon expiration and/or if they are opened and undated with the date of opening using a sample size of 6. QI monitoring will be conducted 5 x weekly for 1 month, then 3 x weekly for 2 months, and then 1 x monthly for 9 months. 4. Facility Administrator/Dietary Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 371	Continued From page 40 An interview with licensed nurse #6 (LN #6) on 4/24/12 at 11:15 AM revealed that due to periods of confusion for Resident #68, she would continue to monitor the Resident for any signs or symptoms of stomach discomfort or distress and notify the physician. LN #6 stated that she had not noticed a change in the resident's condition since the breakfast meal that morning.	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	F 441	1. Resident #19 suffered no harm. Resident #19 no longer has a foley catheter. 2. Regional Director of Clinical Services reviewed all current residents with Methicillin Resistant Staphylococcus Aureus (MRSA) to ensure gowns were worn while facility staff provided catheter care. Regional Director of Clinical Services re-educated the Facility Director of Clinical Services and Nurse Manager on the facility's policy and procedure for infection control for MRSA, including wearing a gown while delivering catheter care. Facility Director of Clinical Services/Nurse Manager re-educated all current facility nursing staff on the facility's policy and procedure for infection control for MRSA,	

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F 441	Continued From page 41 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews the facility failed to utilize a gown while delivering catheter care for a resident (Resident #19) whose urine was positive for Methicillin Resistant Staphylococcus Aureus (MRSA) for one (1) of three(3) sampled residents observed for catheter care. Findings are: Review of the facility policy titled "Infectious Disease- Methicillin-Resistant Staphylococcus Aureus (MRSA)" revised 2/09, revealed the following information: wear clean non sterile gown if you anticipate contact with the source of the infectious agent when caring for the MRSA infected or colonized resident/patient. Review of the Center for Disease Control and prevention (CDC) guidelines for Isolation Precaution titled "Preventing Transmission of Infectious Agents in Healthcare Setting" dated 2007 revealed the following standard precautions to control the spread of MRSA: 4) Gowning Wear a gown, that is appropriate to the task, to	F 441	including wearing a gown while delivering catheter care. 3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring to ensure that facility staff is following facility's policy and procedure for infection control with MRSA, including wearing a gown while delivering catheter care using a sample size of 3. QI monitoring will be conducted 3 x weekly for 1 month, then 1 x weekly for 2 months, and then 1 x monthly for 9 months. 4. Facility Director of Clinical Services/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	5-26-12

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F 441	Continued From page 42 protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated. Resident #19 was readmitted on 3/29/12 with diagnoses of Urinary tract infection and Dementia with Delirium. A lab report dated 4/9/12 documented Resident #19 urine was positive for MRSA. Review of a contact precaution sign posted on Resident #91's door read the following: wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces. During an observation of catheter care on 4/24/12 at 5:12PM, the Director of Nursing (DON) entered Resident #19's room. After performing catheter care the DON disconnected the tubing from the catheter port. She then attached the leg bag to the catheter port. The DON applied a mask and eye shield, then entered the bathroom with the catheter bag and emptied urine into a measuring container. She then discarded the urine into the toilet. At no time during catheter care or contact with catheter bag or tubing did the DON wear a gown. During catheter care the DON stated that she wore a mask and eye shield due to the possibility of urine splashing on her face. Licensed Nurse (LN) #1, whose responsibilities included infection control, was interviewed on 4/27/12 at 10:03 AM. LN #1 explained that the nursing staff was expected and in-serviced to	F 441		

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F 441	Continued From page 43 wear personal protective equipment when providing care that would possibly bring them in contact with an infectious agent. She further stated that in the case of MRSA in the urine staff would be required to wear a gown, mask and eye shield when providing catheter care due to the potential for splash or splatter of urine. During an interview with the DON on 4/27/12 at 11:16AM, the DON revealed that with catheter care there can be a potential for contact with urine. The DON however, explained that because she was providing the catheter care she did not anticipate the need to wear a gown, but it would have been good to wear a gown when providing catheter care for Resident #19.	F 441		