STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 06/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB RD BREVARD, NC 28712

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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, interviews with resident and staff, and medical record review the facility failed to provide activities for one (1) of one (1) sampled alert residents residing on the secure dementia unit. (Resident #124) The findings are: Resident #124 was assessed on the current Minimum Data Set dated 5/7/12 with no cognitive impairment. The current care plan for Resident #124 dated 4/24/12 included a problem area, (Resident's name) enjoys morning coffee, movie time and bingo. Approaches to meet this goal included: Activity calendar posted in room, Invite and encourage resident to attend activities of interest and encourage participation as resident desires/or is tolerated, Assist resident to activities as needed and Provide adaptive equipment as needed. The current activity assessment dated 2/10/12 indicated Resident #124 liked morning coffee, movies (Westerns) and playing bingo. On 5/29/12 at 2:43 PM Resident #124 stated he	F 248	F 248 Residents affected by the alleged deficient practice: Resident #124 was assessed and interviewed, calendar was placed in his room and careplan was updated on June 20, 2012. Administrator provided in service education for Assistant Activity Director on June 7, 2012 regarding logs and activity programming for dementia unit; individual activity logs will be initiated on resident with activities of choice. Facility residents on the Dementia Unit have the potential to be affected by the alleged deficient practice. Administrator provided in service education on 6/7/12 for Assistant Activity Director and education will be provided for Activity Director upon return from FMLA on 7/2/12 regarding appropriate programming of activities for the dementia unit, the use of Activity Logs for each resident in the facility, and that calendars will be **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	6/29/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna J Adams, LNHA — TITLE: Administrator — (X6) DATE: 6/22/12

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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BY:

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F 248	Continued From page 1 was bored because there wasn't anything to do on the secure unit. Resident #124 stated he wasn't aware of an activity calendar on the unit to know if there were any planned activities. Resident #124 stated staff would take him to BINGO upstairs but, other than that, he just hung around the unit. Resident #124 stated he enjoyed watching westerns and that activity staff used to bring movies to the unit but that stopped "awhile back". Resident #124 stated he was so bored he goes to bed early and would participate in activities if they were available. At the time of the interview an activity calendar was not posted in the room of Resident #124. The May 2012 activity calendar posted at the nurses station on the secure dementia unit indicated an "arts and crafts" activity was scheduled on 5/31/12 at 2:30 PM. On 5/31/12 at 2:30 PM observations were made on the secure dementia unit and the "arts and crafts" activity was not observed. On 6/1/12 a June 2012 activity calendar was not observed posted on the dementia unit. Review of the May 2012 activity calendar noted coffee was listed as a daily activity at 10:00 AM. On 6/1//12 at 10:00 AM a coffee activity was not observed on the dementia unit. Review of the May 2012 activity calendar revealed a movie was scheduled every afternoon on Friday. On 6/1/12 (a Friday) at 2:20 PM a movie was observed playing in the dining room on the secure dementia unit. The doors to the main dining room were closed and a resident and family member were the only ones observed watching the movie. The family member stated activity staff had given him the movie to play on 6/1/12. On 6/1/12 at 2:50 PM Resident #124 stated he was not told the movie was playing in	F 248	posted in each residents room and at the nurses station . Systemic Changes: Administrator provided in-service education for the Assistant Director of Activities on June 7, 2012 regarding creating activities designed to meet the needs of residents in the facility, posting of activity calendars in residents rooms, that activity logs are kept on residents and assessed for appropriateness and meeting the needs of the residents. A calendar was designed for residents on the Dementia Unit to provide programming that meets the needs of residents on June 7, 2012. Calendars will be updated monthly and placed in resident's rooms and hallway by Activity Director or Assistant. Activity Director will assess/interview resident on admission/quarterly/annually and significant changes to identify resident's activity needs/requests. Care plans will be updated according to resident needs/requests. Administrator **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 248	Continued From page 2 the main dining room but "came upon it" when walking on the unit. Resident #124 stated it was a movie he had seen before so he didn't stay to watch the remainder of the movie. On 6/1/12 at 3:00 PM the facility administrator stated the activity director was on vacation and couldn't be reached for an interview. The administrator stated she was not aware the assistant activity director had been on vacation 5/31/12 and 6/1/12. The administrator stated the activities probably did not occur in the dementia unit 5/31/12 and 6/1/12 because activity staff was not available. The administrator stated if activities were listed on a calendar she expected them to be done as planned. The administrator located the activity log book for May 2012 and stated there was no record of activities for Resident #124 for May 2012. The administrator stated activity log books for months prior to May 2012 could not be located and attempts had been made to contact activity staff but they could not be reached for interview.	F 248	F248 provided in service education on 6/7/12 for Assistant Activity Director and education will be provided for Activity Director upon return from FMLA on 7/2/12 regarding appropriate programming of activities for the dementia unit, the use of Activity Logs for each resident in the facility, and that calendars will be posted in the residents rooms and at the nurses station. Administrator and/or DON will review Activity Calendar daily Mon-Fri and Weekend Supervisor or Manager on Duty on Saturday and Sunday to ensure activities are occurring as scheduled. Administrator/DON/Activity Director will interview 2 interviewable residents weekly x4 weeks then monthly to assure activity needs/requests are met.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to identify multiple environmental issues on the secure unit in four residents rooms and common use areas.	F 253	QAA: The Administrator/ DON/Activity Director will review data obtained during review and interviews with cognitive residents on the Dementia Unit **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 253	Continued From page 3 The findings are: The following concerns were identified on the secure dementia unit during the four days of the survey: 1. Observations were made 5/29/12 at 1:00 PM, 5/30/12 at 9:30 AM and 5/31/12 at 9:35 AM of a window air conditioner located in the main dining room on the secure dementia unit. Resident dining tables were located against the wall, in close proximity to the location of the window air conditioner unit. To the right of the air conditioner (below the pleated skirting extended out from the air conditioner) was an approximate 6" wide X 2" missing portion of plaster in the window sill. Daylight was visible through the area of missing plaster and nothing was in place to prevent pests from entering into the facility. The hole in the plaster was in close proximity to one of the entrance doors to the facility kitchen. On 6/1/12 at 4:35 PM the maintenance director stated he was aware of the missing plaster and it was on his "list" for repair. 2. Observations were made 5/29/12 at 2:06 PM, 5/30/12 at 10:34 AM and 5/31/12 at 9:00 AM of one of one shower rooms in use on the secure dementia unit. There was not a toilet paper holder or toilet paper available for use by residents using the commode located in the bathroom. On 6/1/12 at 4:35 PM a resident was witnessed coming out of the shower room after using the commode. There was no toilet paper in the shower room at that time for the resident to use after toileting. On 6/1/12 at 5:40 PM the housekeeping supervisor reported her department was responsible for placement of	F 253	F248 and through Resident Council. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 253	Continued From page 4 toilet paper in the shower room. The housekeeping supervisor stated toilet paper would not be left in the shower room without a toilet paper holder. The housekeeping supervisor stated approximately two weeks ago a request had been made for a toilet paper holder and, because it had not been provided, toilet paper was not left in the shower room. 3. Observations were made on 5/29/12 at 2:05 PM, 5/30/12 at 10:15 AM and 5/31/12 at 9:35 AM of a wooden pallet located on an outside common use patio area on the secure dementia unit. This wooden pallet measured approximately 4 1/2' X 3 1/2' and had multiple exposed rusty nails throughout the surface area. The pallet was stored upright at an approximately 60 degree angle and was leaning against a grill in the patio area. Access to this common use area required use of a key pad code. On 5/30/12 at 10:05 AM and 5/31/12 at 9:35 AM a resident and family member were observed seated in this outside area. On 6/1/12 at 4:40 PM the maintenance director stated the common use patio area was available for residents on the secure unit but residents could only go outside with a staff member or family member. The maintenance director stated the wooden pallet should not have been left in the common use area. 4. Observations of a window air conditioner/heating unit in room 306 (a room shared by 3 residents on the secure dementia unit) on 5/29/12 at 4:32 PM, 5/30/12 at 10:30 AM and 5/31/12 at 9:10 AM noted a significant amount of paper like debris located on top of the coils (below the outside cover). In addition, on 5/31/12 at 9:10 AM the top drawer of a bedside	F 253	F 253 Areas/furniture affected by alleged deficient practice were corrected as follows: 1) 6" x 2" missing portion of plaster was repaired and replaced on June 4, 2012, by Maintenance director. 2) Toilet paper holder was repaired and toilet paper replaced in shower room on 6/01/12 by Housekeeping supervisor. 3) Maintenance director removed wooden pallet from outside patio area on 6/1/12. 4) Maintenance director cleaned air conditioner unit in room 306 on June 1, 2012. Maintenance director replaced drawer handle on bedside table in room 306 on June 4, 2012. 5) Maintenance director will repair plaster below air conditioner/heating unit in room 312 by June 29, 2012. 6) Maintenance director repaired loose cover over air conditioner unit in room 314 on June 4, 2012. 7) Maintenance director secured loose junction box in room 323 on June 4, 2012. Maintenance director replaced missing knobs on closet doors in room 323 on June 4, 2012. Hinges on closet **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	6/29/12

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F 253	Continued From page 5 table had a broken metal drawer handle. The handle was broken in half exposing approximately 2" of metal with sharp, jagged edges. Personal resident items were stored inside the drawer. On 6/1/12 at 4:45 PM the maintenance director stated he was not aware of the broken drawer handle. The maintenance director stated he relied on staff to inform him of concerns and they can do this via e-mail, in person or handwritten communication. The maintenance director stated it was the responsibility of housekeeping staff to clean the window air conditioning/heating units. The outside cover of the air conditioning/heating unit was removed by the maintenance director and the debrs on the coils was more readily visible. Upon closer inspection, the debris appeared to be very worn, sheer pieces of crumbled paper. On 6/1/12 at 5:55 PM the housekeeping director stated it was her understanding the maintenance department was responsible for cleaning the coils of the window air conditioning/heating units. The housekeeping director stated her staff should have reported the concern to the maintenance director. 5. Observations were made on 5/29/12 at 2:31 PM, 5/30/12 at 10:30 AM and 5/31/12 at 9:35 AM of the area below a window air conditioning/heating unit in room 312 on the secure dementia unit. The resident's bed in this room was positioned against the wall, in close proximity to this unit. There was an approximate 4" X 6" area below the left hand side of the air conditioning/heating unit with crumbled plaster that was movable to touch. On 6/1/12 at 4:40 PM the maintenance director reported he was not aware of the problem. The maintenance director	F 253	doors in room 323 will be replaced by June 29, 2012. Buckled flooring in room 323 was removed and replaced by Maintenance director on June 20, 2012. Staff Development Nurse (SDC) and Maintenance director began in service education for facility staff on June 19, 2012 regarding procedure for reporting housekeeping and maintenance concerns. Maintenance director and Housekeeping supervisor performed an audit of resident rooms to identify repair and housekeeping needs. Maintenance director and Housekeeping supervisor began to repair, replace or clean areas identified on June 4, 2012. Staff Development Coordinator and Maintenance Director began in service education for staff on 6/19/12 regarding procedure for reporting housekeeping/maintenance issues. Administrator/Maintenance Director/Housekeeping **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 253	Continued From page 6 held a flashlight in the direction of the crumbled plaster and it had a shiny, wet appearance. The maintenance director stated he relied on staff to inform him of concerns and they can do this via e-mail, in person or handwritten communication. 6. Observations were made on 5/29/12 at 3:07 PM and 5/31/12 at 9:30 AM of the cover of the air conditioner/heating unit in room 314 on the secure dementia unit. The cover was loose and pulled away from the wall approximately one inch. The foot of the resident's bed was in close proximity to the unit. On 6/1/12 at 4:45 PM the maintenance director stated he was not aware of the concern and the unit covers should not be loose from the wall. The maintenance director stated he relied on staff to inform him of concerns and they can do this via e-mail, in person or handwritten communication. 7. Observations were made on 5/29/12 at 3:18 PM, 5/30/12 at 10:42 AM and 5/31/12 at 9:15 AM inside room 323 on the secure dementia unit.. The two residents in the room were ambulatory and able to access all areas within their room. A junction box was hanging out of the wall (in an area around the head of the resident beds) by wires and extended out from a hole in the sheetrock. Wall anchors were attached to the junction box. In addition, an approximate 4" X 4" area of buckled broken flooring was observed approximately 1/2" in front of the two door wardrobe utilized by one of the residents. On 5/31/12 at 9:15 AM the two door wooden wardrobe closet (closest to the door) was noted to be missing a door pull/knob on the right hand door. There was a pre-drilled hole in the door	F 253	Supervisor will conduct rounds weekly in resident rooms and common areas to identify cleanliness of areas and areas/furniture/equipment in need of repair or replacing. Staff Development Coordinator and Maintenance Director began in service education for staff on 6/19/12 regarding procedure for reporting housekeeping/maintenance issues. Ambassadors/Department managers will make daily rounds Monday through Friday and RN supervisor and/or Manager on Duty on Saturday and Sunday to observe residents rooms for maintenance/housekeeping issues. Repair forms will be completed and placed in Maintenance Directors' box when an issue is identified. Maintenance director will retrieve repair forms daily Monday through Friday and follow through with necessary repairs. Administrator will conduct rounds throughout the facility **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 253	Continued From page 7 where the pull/knob would be located. The closet area behind this right hand door was filled with resident personal belongings. The right hand door of the two door wooden wardrobe closet (closest to the window) was not able to close flush against the wardrobe and appeared wobbly. Upon opening this door, three of four hinges which attached the door to the closet were not fully attached. The two bottom hinges were broken and not attached to the door. The upper hinge (above the two lower) was loose and not firmly attached. The left hand door of this two door wooden wardrobe closet (closest to the window) was noted to be missing a door pull/knob. There was a pre-drilled hole in the door where the pull/knob would be located. On 6/1/12 at 5:00 PM the maintenance director stated he was not aware of any of the concerns in room 323. The maintenance director stated the junction box hanging out of the wall was for telephone wires. The maintenance director stated there should be knobs/pulls on wardrobe doors to prevent residents from pinching their fingers when opening or closing the door. The maintenance director stated he relied on staff to inform him of concerns and they can do this via e-mail, in person or handwritten communication. On 6/1/12 at 7:00 PM the facility administrator stated she expected nursing and housekeeping staff to report any environmental concerns to the housekeeping or maintenance director. The administrator stated the facility also had an "ambassador" program which assigned an individual staff member to each resident in the facility. The administrator stated one of the daily expectations of the ambassador was to check the	F 253	with Maintenance Director three times a week for 4 weeks then weekly ongoing to assure continued compliance. QAA Administrator and or Maintenance Director will review data obtained during rounds and audits. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 253	Continued From page 8 resident and their room and to report any environmental concerns to the housekeeping or maintenance director.	F 253	F 309 Resident affected by the alleged deficient practice: Physician assessed resident #29 and reviewed chart on 6/2/12. Resident #29 was not exhibiting signs or symptoms of urinary discomfort or hematuria when assessed, so therefore no new orders were written. Resident #29 had bowel movement on 5/30/12. The Director of Nursing (DON) Unit Mangers and Staff Development Coordinator (SDC) began in service education for staff on 6/19/2012 regarding following physician orders, and monitoring of bowel function. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing reviewed care tracker information for current facility residents beginning 6/4/12 to identify residents that did not have a bowel movement for the last nine shifts or three days. The licensed	
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 medical record review and staff interviews the facility failed to obtain a laboratory specimen and administer standing orders for constipation per physician orders for one (1) of ten (10) sampled residents (Resident #29). The findings are: 1. Resident #29 was re-admitted to the facility on 01/23/12 with diagnoses including urinary tract infection (UTI), urinary retention, and cerebral vascular accident with hemiparesis. The most recent Minimum Data Set, a quarterly review, dated 04/12/12 revealed Resident #29 was totally dependent on staff for activities of daily living and had an indwelling urinary catheter. A review of Resident #29's medical record revealed a physician's order dated 04/13/12. The order specified Urinalysis (UA) and Culture and Sensitivity (C&S) in one week, if still has	F 309	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 309	Continued From page 9 hematuria (blood in the urine), refer to urology. A nurse's note dated 04/13/12 revealed a new order for UA/C&S in one week, if still has hematuria, refer to urology. A nursing care plan last updated on 04/20/12 for indwelling urinary catheter revealed the resident had urinary retention and a history of frequent UTIs. Interventions included assess urine and monitor labs. Continued medical record review revealed no documentation that a UA/C&S was collected and sent to the laboratory one week after the original order was written. A nurse's note dated 05/01/12 revealed Resident #29 had a temperature of 101 degrees Fahrenheit, the physician was notified and an order was obtained to send a urine specimen to the laboratory. A laboratory report with a completion date of 05/02/12 revealed Resident #29's urinalysis was positive for a large amount of blood and contained 4+ bacteria. An order written on the laboratory report revealed Levaquin (an antibiotic) 500 milligrams (mg) by mouth daily for ten days. An interview with Unit Manager (UM) #1 on 06/01/12 at 2:00 PM revealed when an order for lab work is transcribed the nurse should fill out a lab slip and place it on a clipboard or the calendar at the nurses' station. If the lab specimen was not obtained during the shift, the nurse should pass the information on to the on-coming shift nurse. UM #1 also revealed the lab slip should be dated	F 309	nurse medicated the residents that were identified with laxatives as ordered or notified physician for orders. The Director of Nursing (DON) Unit Mangers and Staff Development Coordinator (SDC) began in service education for staff on 6/19/2012 regarding following physician orders, and monitoring of bowel function. Systemic Changes: The Director of Nursing (DON) Unit Mangers and Staff Development Coordinator (SDC) began in service education for nursing staff on 6/19/2012 regarding following physician orders, and monitoring of bowel function. SDC will review care tracker documentation for newly hired nursing assistants to include all aspects of documentation including monitoring of bowel function, during new hire orientation. SDC will review noting and following physician orders for licensed nurses during new hire orientation. DON/Unit Managers/RN supervisors will **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 309	Continued From page 10 when the lab was due to be collected. During the interview UM #1 looked at the April, 2012 calendar and the request for a UA on Resident #29 was written under the 04/20/12 date. The entry had a strike through and a "not needed" notation written by the request. UM #1 indicated she did not know why the order had been struck through and stated the lab should have been collected, unless the physician cancelled the order. An interview was conducted with Licensed Nurse (LN) #4 on 06/01/12 at 2:30 PM by telephone. LN #4 was the assigned nurse for the night shift beginning 04/19/12. LN #4 indicated she did not remember if she marked out the lab request on the calendar for Resident #29's UA. LN #4 further indicated she would not have crossed out the laboratory test without a physician's order. The attending physician was interviewed on 06/01/12 at 3:30 PM and revealed he ordered the urinalysis as a follow up from a UTI Resident #29 was being treated for at the time of the order. The attending physician indicated he expected the order of 04/13/12 to be carried out and he did not give an order to cancel the test. 2. Resident #29 was re-admitted to the facility on 01/23/12 with diagnoses including urinary tract infection, urinary retention, and cerebral vascular accident with hemiparesis. The most recent Minimum Data Set, a quarterly review, dated 04/12/12 revealed Resident #29 was totally dependent on staff for activities of daily living. A physician order dated 04/06/2011 revealed;	F 309	print care tracker documentation daily for bowel movements indicating no bowel movement in last nine shifts. Report will be given to licensed nurse to medicate resident as ordered or notify physician for orders. Medication administration will be documented on Medication Administration record and bowel movements will be documented in care tracker. DON and/or Unit Managers will review Care tracker reports daily Monday through Friday to identify and follow up for residents with no bowel movements in the last 9 days to assure interventions and monitoring are in place. QAA: The DON and or Administrator will review data obtained from audits to ensure continued compliance. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 309	Continued From page 11 Milk of Magnesia (MOM) 30 Milliliters (ml) by mouth every day as needed for constipation. Give every three (3) days as needed if no bowel movement (BM). Resident #29's bowel elimination records were reviewed for April and May, 2012 and revealed the following: a. Starting 04/06/12 through 04/11/12, sixteen (16) shifts, no bowel movements were documented. b. Starting 04/17/12 through 04/21/12, fourteen (14) shifts, no bowel movements were documented. c. Starting 05/24/12 through 05/29/12, fifteen (15) shifts, no bowel movements were documented. Review of Resident #29's Medication Administration Records for April and May, 2012 revealed no documentation of MOM given during the above documented periods when Resident #29 experienced no BM for more than three days. An interview with Licensed Nurse (LN) #3 on 06/01/12 at 1:06 PM revealed residents' BMs were documented in the computer each shift by Nursing Assistant staff. LN #3 stated LN staff printed a "no bowel movement in three days" report and should have given the resident MOM 30 ml. LN #3 further revealed if there were no results during her shift the on-coming nurse should be notified. The attending physician was interviewed on 06/01/12 at 3:40 PM and revealed as needed (PRN) orders were available for residents who	F 309	develop and implement additional interventions as needed to assure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 309	Continued From page 12 were constipated. The attending physician indicated five (5) days is too long for a resident to go without a BM and would have expected nursing to give the resident a laxative on the third day without a BM. On 06/01/12 at 4:35 PM an interview was conducted with Unit Manager #1. She stated based on the physician's order, Resident #29 should have received MOM on the third day without a BM.	F 309	F 314 Corrective action has been achieved for the alleged deficient practice in regards to Resident #106. Resident #106 was readmitted to the facility on 5/01/12. Nursing Admission assessment was completed on 5/01/12, which included a skin assessment and Braden scale. A skin assessment was completed by the licensed nurse on 5/08/12 and again on 5/17/12. On 5/14/12, the licensed nurse identified an ulcer on the residents left heel. Physician was notified and treatment orders were received. Director of Nursing (DON), Staff Development coordinator (SDC) and Unit coordinators began in service education for licensed nurses and nursing assistants on 6/19/12 regarding assessment, monitoring and reporting changes in skin condition. Current facility residents have the potential to be affected by the alleged deficient practice. Skin assessments were done on current facility residents by licensed nurses beginning 6/2/12, to identify residents with changes in skin **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	6/29/12
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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, resident and staff interviews, and record review the facility failed to assess a pressure ulcer and initiate treatment for 14 days for one (1) of (1) sampled residents. (Resident # 106) The findings are: Resident # 106 was admitted to the facility on 08/13/10 with diagnoses including: acute renal failure, hypertension, cerebral vascular accident	F 314		

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F 314	Continued From page 13 with left sided weakness, muscle atrophy and chronic obstructive pulmonary disease. Resident #106 was hospitalized 04/27/12 and re-admitted to the facility on 05/01/12. Review of the resident 's hospital admission history and physical dated 04/27/12 revealed the resident was admitted to the hospital for treatment of acute hypoxic respiratory failure secondary to pneumonia and had a stage II pressure ulcer on his left heel. Review of the post hospital nursing admission assessment dated 05/01/12 and a nursing note dated 05/01/12 indicated no pressure ulcers were observed. The Braden scale (an assessment tool used to determine a resident's risk for the development of pressure ulcers) dated 05/01/12 revealed resident at high risk for developing a pressure ulcer related to limited mobility and extensive assistance with activities of daily living (ADL's). Review of the resident's Minimum Data Set dated 05/09/12 revealed the resident was cognitively intact, had no pressure ulcers, had an indwelling urinary catheter, was incontinent of bowel and required extensive assistance with ADL's including; bed mobility, transfers, personal hygiene and toileting. Review of Resident #106's plan of care, updated 05/14/12 revealed a risk for skin breakdown related to limited mobility and extensive assistance with ADL's. The goal was the resident would not have any additional pressure ulcers and healing of current pressure ulcer. Interventions included, incontinence care and	F 314	condition. DON and Unit Managers reviewed the identified residents charts to assure assessments were done and treatment orders were initiated. DON, SDC and Unit Managers began in service education with nursing staff on 6/19/12, regarding skin assessment, monitoring and reporting changes in skin condition. Monitors put into place to ensure the alleged deficient practice does not recur include: DON, SDC and Unit Managers began in service education with nursing staff on 6/19/12, regarding skin assessment, monitoring and reporting changes in skin condition. DON, Unit Managers and RN supervisors will review new admission assessments daily to assure skin assessment was performed on admission and treatments were initiated as necessary. DON and/or Unit Managers will conduct weekly compliance rounds on five residents to observe skin condition and accuracy of skin assessments. Concerns identified will be addressed at that time and appropriate interventions initiated. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 314	Continued From page 14 assistance with ADL's provided by staff, a pressure reducing mattress and blue skin protective boots on both feet. Review of the head to toe skin assessment dated 05/14/12 revealed the resident had a Stage III pressure ulcer on his left heel that measured 1.3 centimeters (cm) long x 1.3cm wide x 0.3cm deep with fifty percent slough (dead tissue) in the base of wound. On 05/14/12 a physician's order was written to initiate treatment to a stage III pressure ulcer on left heel as follows; cleanse with NS (normal saline), apply alginate dressing, cover with foam dressing and secure with gauze wrap and tape daily. On 05/31/12 at 10:45am the facility's Director of Nursing (DON) was interviewed. The DON affirmed Resident #106 had a stage III (3) pressure ulcer on his left heel that was discovered by staff on 05/14/12. The DON was unable to provide further information why the pressure ulcer had not been identified until it was a stage III on 05/14/12. On 05/31/12 at 11:30am Resident #106's left heel pressure ulcer was observed as Licensed Nurse (LN) #3 and LN #6 performed treatment to the ulcer. The resident's pressure ulcer was measured by LN #6 as 1.3cm long x 1.1cm wide x 0 1cm deep, with yellow slough in the base of the ulcer. On 05/31/12 at 11:35am an interview with Resident #106 revealed the staff did not remove his blue boots everyday and look at his feet.	F 314	QAA: The DON and/or Administrator will review data obtained during compliance rounds to determine continued compliance. Patterns/trends will be identified and analyzed and reported in QA&A weekly for four weeks then monthly thereafter. The QAA committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 314	Continued From page 15 On 05/31/12 at 11:55am an interview with LN #6 revealed she had assessed the resident and found a stage III pressure ulcer on the back of his left heel on 05/14/12. LN #6 indicated head to toe skin assessments are to be performed weekly on the resident by nursing staff and documented on the head to toe skin assessment form. LN #6 recalled she performed a head to toe assessment on 05/14/12 but did not recall any prior assessments being completed following the resident's facility admission on 05/01/12. On 05/31/12 at 3:45pm an interview with Unit Manager #1 revealed physician orders are checked by her and matched with the treatment administration record (TAR). Interview revealed the nurse that completed the skin assessment form on Resident #106 on 05/01/12 no longer worked at the facility. On 05/31/12 at 5:10pm an interview with NA #4 revealed she was assigned to Resident #6 on most nights she worked second shift. Interview revealed she goes in to turn and reposition resident several times during her shift and she had assisted the resident with bathing after his hospitalization. Interview revealed NA #4 "believed the resident had an open area on the back of his left heel, but she couldn't remember". NA #4 also revealed she "couldn't remember telling the nurse". On 06/01/12 at 8:15am an interview with NA #3 revealed he had re-applied the resident's blue boots after providing incontinent care and assistance with bathing the resident. Interview revealed NA #3 did not observe the back of the	F 314		

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F 314	Continued From page 16 resident's heel because it was difficult for the resident to straighten his left leg and it was hard to see the back of the heel. Interview revealed NA#3 "can't remember if the resident had any places on his left heel or not". On 06/01/12 at 9:00am an interview with LN #5 revealed she could not recall performing a head to toe skin assessment for Resident #106 following the resident's hospitalization. On 06/01/12 at 9:50am an interview with the MDS Coordinator revealed the nursing admission skin assessment dated 05/01/12, indicating the resident did not have a pressure ulcer was used to code Resident #106's MDS.	F 314	F 325 Resident affected by the alleged deficient practice: The licensed nurse notified the physician on 6/11/12 about Resident #91 regarding the order for a nutritional supplement. Physician clarified supplement order for resident #91. Director of Nursing (DON) and Staff Development Coordinator (SDC) began in service education for licensed nurses on 6/18/12, regarding "Weight and Hydration Management and documentation of supplements on the Medication Administration Record (MAR).	6/29/12
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow a physician's order to administer a nutritional supplement for one (1) of three (3) sampled residents reviewed for	F 325	Current facility residents that have orders for nutritional supplement have the potential to be affected by the alleged deficient practice. DON and Unit Managers identified residents with orders for nutritional supplements on 6/22/12. DON and Unit managers audited June 2012 MARs of identified residents to assure nurses were documenting that residents were **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 325	Continued From page 17 unintended weight loss. (Resident #91). The findings are: Resident #91 was admitted to the facility with diagnoses including malnutrition, iron deficiency anemia, osteoporosis, and dementia. A review of Resident #91's medical record revealed a physician's order dated 04/06/12. The order specified four (4) ounces of a nutritional supplement were to be administered three (3) times a day after meals. A review of Resident # 91's Medication Administration Record (MAR) for April 2012 revealed the supplement was initialed by nurses beginning 04/07/12 indicating the supplement was administered as ordered. Resident #1's latest Minimum Data Set (MDS) dated 04/12/12 indicated impairment of memory and cognition and dependence on staff assistance for all care including eating. The MDS was completed due to significant weight loss. The resident' s weight was recorded as 112 pounds. The previous MDS dated 01/19/12 recorded the resident's weight as 125 pounds. A review of Resident #91's nutrition care plan dated 04/12/12 revealed the resident had experienced actual weight loss related to an acute illness and chronic malnutrition. The care plan goal specified the resident's weight would stabilize within 90 to 110 pounds through the next 90 days. Care plan interventions included provide diet and nutritional supplements as ordered by the physician.	F 325	receiving supplements as ordered. DON and SDC began in service education for licensed nurses on 6/18/12, regarding "Weight and Hydration Management and documentation of supplements on the Medication Administration Record (MAR). DON and SDC began in service education for licensed nurses on 6/18/12, regarding "Weight and Hydration Management and documentation of supplements on the Medication Administration Record (MAR). DON/Unit Managers/RN Supervisors will review telephone orders daily to identify new orders for nutritional supplements and compare to MAR to assure transcription onto MAR and documentation of administration of the supplement as ordered. DON/Unit Managers and RN supervisors will conduct audits of MAR three times a week for four weeks then weekly for residents identified with orders for nutritional supplements to assure documentation of **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 325	Continued From page 18 A Care Area Assessment (CAA) dated 04/23/12 specified a change in condition related to a recent hospitalization resulting in a significant weight loss in the past thirty (30) days. The CAA indicated on 04/06/12 a nutritional supplement was ordered three times a day for nutritional support. Continued medical record review revealed Resident #91's May 2012 MAR contained the order for the nutritional supplement. No nurses' initials to indicate the supplement was administered were observed on the MAR. Additional medical record review revealed Resident #91's weight recorded 05/25/12 was 107. An interview was conducted with Licensed Nurse (LN) #1 on 06/01/12 at 10:30 AM. She stated she had worked on Resident #91's hall most of the month of May on the day shift. LN #1 added she did not see the order on the May MAR for the nutritional supplement and did not administer it. An interview with the Director of Nursing (DON) on 06/01/12 at 1:11 PM revealed she expected physician's orders were followed.	F 325	administration of the supplement as ordered. The Administrator/DON will review audits and identify patterns or trends and report trends in Quality Assessment and Assurance (QAA) Committee weekly for four weeks then monthly thereafter. The QAA Committee will evaluate the effectiveness of the above plan and adjust the plan based on trends identified.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient	F 353	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 353	Continued From page 19 numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide sufficient nursing staff to deliver meal trays and supervise residents during one (1) of two (2) dining observations in the secured unit. The findings are: An observation of the evening meal was conducted in the secured unit on 05/29/12 from 5:04 PM to 5:39 PM. Nursing Assistants (NA) #1 and #2 were observed serving all trays. Table #1 had two (2) residents sitting across from each other. Tables #2, #3, #4, and #5 were observed with a total of four (4) residents sitting at each table. Tables #1 through #4 were arranged in a row with one end against a wall in the dining room. Table #5 was on the other side of the dining room with one end of the table against the opposing wall. The NAs were observed removing meal trays from a cart located in the hallway	F 353	F 353 The Administrator and Director of Nursing (DON) observed dining process in the dementia unit for lunch and dinner meals beginning 6/4/12. The process was changed to have sufficient staff members in the Dementia unit dining room during lunch and dinner meals to assist with passing, feeding and monitoring of residents during meals. The DON and Staff Development Coordinator (SDC) began in service education for nursing staff and department managers on 6/4/12, to implement expectation of staff assistance in the Dementia unit dining area during lunch and dinner to assist with passing of trays, assisting residents as needed and monitoring of residents during meal time. Residents on the Dementia unit have the potential to be affected by the alleged deficient practice. DON and SDC provided in service education for the nursing **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	6/29/12

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	345208	A. BUILDING _____ B. WING _____	C 06/01/2012

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F 353	Continued From page 20 immediately outside the dining room. A resident at Table #1 was one of the first residents served. The resident sitting across from him was observed picking up a bowl from the tray and drinking the contents. The NAs were unaware of this activity as they continued to serve meal trays to other residents. The residents at Table #2 were served their meal trays at different times. The resident who was observed being served first pushed his tray to the middle of the table after eating a few bites. The resident sitting across from him was observed pulling the tray to his side of the table and began eating from the tray with his fingers. The two (2) NAs were unaware of this activity as they continued to serve meal trays to other residents. At 5:24 PM a resident at Table #4 was observed removing all the cups and bowls of food from the tray of the resident sitting across the table. Some of the dishes contained food and some did not. At 5:26 PM, NA #2 observed this behavior and replaced the dishes to the tray. An observation of the lunch meal on 5/30/12 at 11:20 AM revealed three (3) nurses and two (2) nursing assistants in the dining room. The residents were observed receiving the assistance they required in a timely manner. No residents were observed eating food from other residents' trays. An interview with NA #1 on 05/31/12 at 5:05 PM revealed it was very difficult to serve all the meal trays in a timely manner and supervise the residents with only two nursing assistants. He stated some of the residents were prone to eat off	F 353	staff and department managers on 6/4/12, to implement the expectation of staff assistance in the Dementia unit dining area during lunch and dinner to assist with passing of trays, assisting residents as needed and monitoring of residents during meal time. The Administrator, Director of Nursing and Unit Managers will observe dining during lunch and dinner in the dementia unit three times a week for 4 weeks then weekly to assure sufficient staff is available and assisting as needed during meal time. DON and SDC provided in service education for the nursing staff and department managers on 6/4/12, to implement the expectation of staff assistance in the Dementia unit dining area during lunch and dinner to assist with passing of trays, assisting residents as needed and monitoring of residents during meal time. The Administrator, Director of Nursing and Unit **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 353	Continued From page 21 other residents' trays. NA #1 stated behaviors in this unit were known to escalate in the afternoon. He added when there are three (3) nursing assistants it is easier to watch the residents and supervise their behavior. An interview was conducted on 5/31/12 at 5:16 PM with the Administrator and the Director of Nursing (DON). The Administrator and the DON acknowledged more than two (2) staff members were needed in the secured unit so residents could be served and supervised during the evening meal.	F 353	Managers will observe dining during lunch and dinner in the dementia unit three times a week for 4 weeks then weekly to assure sufficient staff is available and assisting as needed during meal time. The Administrator and DON will review data obtained during observations. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure 1) cold food items were at safe temperature on the tray line, 2) food was not stored beyond expiration, 3) equipment in the kitchen was clean and safe for use, and 4) overhead pipes were free from peeling paint. The findings are:	F 371	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 371	Continued From page 22 1. During the initial tour of the facility kitchen on 5/29/12 at 10:20 AM a one gallon container of reduced fat milk was observed stored on shelving in the walk in refrigerator. There was approximately 1/4 gallon of milk remaining in the container and it had a manufacturer label with a expiration date of 5/22/12. On 5/29/12 at 11:10 AM the Food Service Director (FSD) stated it was the responsibility of staff to look in the walk in refrigerator every day for any expired food items. The FSD stated expired foods should be removed and discarded and staff had missed identifying the milk was out of date. 2. On 5/31/12 at 9:55 AM an approximate two foot portion of painted metal pipe was observed in the ceiling above the clean area of the dish machine and over an area where clean dishware was stored. The majority of the underside of the pipe was rusted with large pieces of peeling paint hanging over the clean dishware. This was observed again on 6/1/12 at 4:00 PM with the peeling paint over clean dishware. The Food Service Director was present at the time of the observation and stated when staff observe peeling paint they usually report it to the maintenance director for repair. 3. On 5/31/12 at 9:55 AM a fan was observed on high speed, blowing on clean dishware. The fan was positioned approximately five feet from ground level and blowing on clean dishware that had been pulled from the dish machine. The fan was turned off and the majority of the surface area of the outer perimeter of the blades was covered with a black dusty appearing substance. On 6/1/12 at 4:00 PM the fan was not running but the blades remained with the same black dusty	F 371	F 371 Areas affected by the alleged deficient practice were corrected: 1) Milk was discarded on 5/29/12 2) Metal pipe in the ceiling above the dish machine was cleaned and repainted by the Maintenance director on 6/4/2012. 3) The fan blades were cleaned by Maintenance Director on 6/4/2012. 4) The juice dispenser nozzle was cleaned by Food Service Director on 5/31/12. 5) The Food Service Director removed the pimento cheese from the line and placed into the walk in freezer when she was made aware of concern on 5/31/12. 6) The knife with the broken tip and nick in blade was removed from the kitchen and disposed of properly by the Food Service Director on 6/01/12. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	6/29/12

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F 371	Continued From page 23 appearing substance. The Food Service Director (FSD) was present at the time of the observation and stated the fan was a replacement for one that recently broke. The FSD stated staff wiped the front and back grill of the fan but could not figure out how to open the grills to access the blades for cleaning. 4. On 5/31/12 at 9:55 AM the inside of a juice dispenser nozzle used for water, apple cranberry juice and prune juice had a significant amount of slimy matter (which affected approximately half of the surface area) in the holes of the dispenser. This matter came into direct contact with the water and juice as it was dispensed from the machine. The Food Service Director (FSD) removed the outer nozzle and, on closer inspection, individual spores could be seen in the matter and it was easily removed by touch. The FSD stated the nozzle was supposed to be cleaned every day and thought it had been cleaned the day prior. 5. On 5/31/12 at 4:30 PM observations were made of the cook taking food temperatures before start of the supper tray line. Prior to taking the temperatures the cook stated the temperature of the pimento cheese may "not be cold enough" because it had not been made the day prior. The cook stated her practice was to make cold items the day ahead so food would be served at an appropriate temperature. The cook stated she did not work the day prior and, as soon as she arrived at work she made the pimento cheese and placed it in the walk in refrigerator. The cook stated she removed the pimento cheese from the walk in and placed it on the tray line at approximately 4:15 PM. The pimento cheese	F 371	Facility residents have the potential to be affected by the alleged deficient practice. The Food Service Director (FSD) audited the kitchen storage areas including the refrigerator and freezer on 5/31/12 to identify food products with expired dates or improper dating/labeling. Food products that were expired or not dated/labeled appropriately were discarded. The FSD and Administrator performed rounds in dietary department to identify areas of repair, painting or replacement. Concerns identified were addressed with the Maintenance director by the Administrator to develop a plan for repair, replacement and/or painting. The FSD and dietician developed a cleaning schedule for the dietary department to include but not limited to the fans, juice dispenser, and equipment in dietary department. The FSD and dietician provided in service education for the dietary staff on 6/12/12, regarding "Taking temperature of food items, process for keeping food items at **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 371	Continued From page 24 was observed in pans over ice. The temperature of a pimento cheese sandwich on the tray line was 53 degrees Fahrenheit (F) and puree pimento cheese was 62 degrees F. The cook commented she could put the pimento cheese sandwich and puree pimento cheese in the freezer but the pans were not moved and the supper meal service started at 4:50 PM. On 5/31/12 at 5:05 PM the Food Service Director (FSD) stated the pimento cheese should have been made the day prior but staff did not have time to make it. The FSD stated the AM cook had extra duties which prevented her from making the pimento cheese earlier in the day. The FSD placed the thermometer (that had been used by the cook to take temperatures) in an ice bath and the temperature was 48 degrees F (instead of 32 degrees F). At 5:20 PM the FSD checked another thermometer for accuracy and, once verified, took temperature of the pimento cheese while it continued to be served on the tray line. The temperature of the pimento cheese sandwich was 45 degrees F and the temperature of the puree pimento cheese was 50 degrees F. At the time the temperatures were taken trays had already been delivered to the west wing and trays were actively being plated for the south wing. The FSD placed the puree pimento cheese into smaller pans and directed staff to put it in the walk in freezer. Sandwiches were also removed and placed in the walk in freezer. 6. On 6/1/12 at 4:00 PM a knife was stored ready for use in the food preparation area. Approximately 1/8" of the tip of the knife blade was missing and an approximate 1/8" nick was noted midway on the blade. The Food Service	F 371	appropriate temperatures, cleaning of equipment, and disposal of equipment that is broken." The FSD and dietician provided in service education for the dietary staff on 6/12/12, regarding "Taking temperature of food items, process for keeping food items at appropriate temperatures, cleaning of equipment, and disposal of equipment that is broken." Random observation daily Monday through Friday x2 weeks then weekly by Dietary manager/designee, and/or Administrator to assure dietary department and equipment are being cleaned according to schedule. Random observations daily Monday through Friday x 2 weeks then weekly by the Dietary manager/designee, and/ or Administrator to assure food items have been labeled and dated appropriately and expired items have been disposed of appropriately. Random observations daily Monday **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 371	Continued From page 25 Director was present at the time of the observation and reported staff should not use a knife with a damaged blade and it should have been reported to her so the knife could be discarded.	F 371	F371 through Friday x 2 weeks then weekly by the Dietary manager/designee, and/or Administrator to assure that broken or damaged utensils are not in use. Dietary manager/designee and Administrator will make daily rounds Monday through Friday x 2 weeks then weekly to assure continued compliance using Sanitation Checklist. Issues identified will be discussed in weekly QA&A meetings x4 weeks, then monthly thereafter. The Dietary manager/designee and or Administrator will review data obtained during the daily random observations, analyzing for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.	
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to report a critical laboratory value to the attending physician for one (1) of one (1) sampled residents that received dialysis. The findings are: Resident #1 was readmitted to the facility with diagnoses including end stage renal disease and diabetes mellitus. A care plan dated 12/19/11 indicated Resident #1 received hemodialysis three times a week. The care plan goal specified the facility would provide safe, accurate, and appropriate care assessments to improve resident outcomes through the next review. Care plan interventions included monitor laboratory work and notify the physician as indicated. On 05/31/12 at 9:04 AM a review of a notebook containing reports from the dialysis center regarding Resident #1's care was conducted. A report dated as printed 05/24/12 contained a Potassium level that was obtained 05/21/12. The report specified the result was 6.8 and stated the	F 505	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 505	Continued From page 26 Potassium level was dangerously high. The report continued with a list of foods to be avoided. A review of Resident #1's medical record revealed no documentation to indicate the attending physician was notified of the high potassium. An interview with Unit Manager (UM) #1 during the review of the above report was conducted. She stated the resident sometimes brought a report with him from dialysis. The reports were placed in the notebook labeled "Dialysis". UM #1 was unaware of the high potassium report until this time. An interview with the Food Service Director on 05/31/12 at 11:03 AM revealed she had received the report noting the high Potassium and list of foods to avoid. She stated the report was faxed to her from the dialysis center on 05/24/12. She, in turn, sent a copy of the report to the nursing staff on the unit which Resident #1 resided. An interview with the Attending Physician on 06/01/12 at 3:10 PM revealed he was not aware of the critical value for the Potassium until 05/31/12. He stated he expected to be notified in a timely manner of any critical laboratory report received from the dialysis center.	F 505	F 505 The Physician was notified on 6/01/12, regarding the potassium lab result for resident # 1. New orders were received and implemented for resident #1. The Unit Manager notified the dialysis center on 6/4/12, and requested that the lab results are to be faxed to the nursing station fax machine or return with the resident to the facility. The Director of Nursing and/or the Unit Managers began in service education for licensed nursing staff on 6/19/12 regarding policy and procedure for obtaining labs from dialysis and notification of facility physician regarding lab results. Facility residents that receive dialysis have the potential to be affected by the alleged deficient practice. On 6/01/12, the DON and Unit Managers identified residents that are receiving dialysis and reviewed the chart for lab orders and results. Physician was notified regarding	6/29/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 514	Continued From page 27 systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure the June 2012 physician order sheet and Medication Administration Record (MAR) was accurate for one (1) of ten (10) sampled residents. (Resident #82) The findings are: Resident #82 had diagnoses including dementia without behavior disorder. Review of physician orders in the medical record of Resident #82 revealed an order dated 1/6/12 for 125 milligrams (mg) of Depakote at 2:00 PM. At the time of the review on 6/1/12 there had been no changes to the Depakote for Resident #82 since ordered on 1/6/12. The June 2012 physician order sheet and June 2012 MAR (located in the medication book and in use by licensed staff) for Resident #82 noted the dosage of Depakote as 250 mg, not 125 mg as ordered. On 6/1/12 at 3:15 PM the physician of Resident #82 stated the Depakote was ordered for behaviors, not seizures. On 6/1/12 at 10:03 AM unit manager #2 stated the monthly physician order sheets and MARs for	F 514	lab results and orders were received as necessary. On 6/4/12 the Unit Managers notified the dialysis clinic to request that lab results are to be faxed to the nursing station or returned with resident to the facility. The Director of Nursing and/or the Unit Managers began in service education for licensed nursing staff on 6/19/12 regarding policy and procedure for obtaining labs from dialysis and notification of facility physician regarding lab results. The Director of Nursing and/or the Unit Managers began in service education for licensed nursing staff on 6/19/12 regarding policy and procedure for obtaining labs from dialysis and notification of facility physician regarding lab results. The Staff Development Coordinator (SDC) will in service licensed nurses during new hire orientation. The DON and/or Unit managers will review telephone orders daily Monday through Friday to **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 514	Continued From page 28 each resident were typed and printed by one of three facility staff (two unit managers and a nursing assistant/unit secretary). Unit manager #2 reviewed the medical record of Resident #82 and verified there had been no changes of Depakote since the 1/6/12 order. Unit manager #2 reviewed the Depakote order in the facility computer system (which was used to generate the monthly physician orders and MARs) and could offer no explanation how the order was changed from 125 mg to 250 mg of Depakote. Unit manager #2 spoke to the other two staff members responsible for processing the physician order sheets and MARs and they did not recall changing the dosage of the Depakote. Unit manager #2 stated the computer system did not identify which of the three had processed the June 2012 physician order sheet and MAR. Unit manager #2 noted the June 2012 physician order sheet and MAR for Resident #82 had been signed as reviewed for accuracy by two separate licensed nurses, LN #2 and LN #3. Unit manager #2 stated the nurses that reconcile the monthly physician order sheet and MAR should identify and correct any errors prior to placement of the MAR in the medication administration book. On 6/1/12 at 10:10 AM LN #3 verified she had signed the physician order sheet for Resident #82 which indicated she did a second check of medications. LN #3 stated when doing the review she only checked any new physician orders against the June 2012 MAR. LN #3 stated the order for Depakote had not been changed since 1/6/12 for Resident #82, so the wrong dosage on the June physician order sheet and MAR would not have been identified by her during her reconciliation. LN#3 corrected the dose of	F 514	identify new orders for labs, monitor for receipt of lab results and notification of physician. Unit Managers and/or licensed nurses will review Dialysis Communication form for identified residents upon return from dialysis to monitor for labs obtained at dialysis and facility physician will be notified regarding results. The DON and/or unit managers will review data obtained from monitors and audits. Patterns/trends will be identified and analyzed and reported in QA&A for four weeks then monthly. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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(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 514	Continued From page 29 Depakote on the June MAR noting the resident had not received the wrong dose of Depakote because the dose was not scheduled to be given until 2:00 PM. On 6/1/12 at 12:30 PM an attempt was made to contact LN #2. On 6/1/12 at 5:38 PM via phone interview LN #2 verified she checked the June 2012 MAR for Resident #82. LN #2 stated her process of reconciling included checking the residents May 2012 MAR to the June 2012 MAR. LN #2 stated if there were any discrepancies in the June 2012 MAR she would have reviewed the residents medical record and made corrections as indicated. LN #2 stated the review included looking at both drugs and dosage and that a second check by another nurse should identify any missed problems. LN #2 indicated the review of the physician order sheet and MAR would be completed prior to placement of the MAR in the medication administration book. On 6/1/12 at 12:55 PM the Director of Nursing (DON) stated a triple check of the physician order sheet and MAR should be done by nurses prior to placement of MARs in the medication administration book. The DON stated the triple check would be divided up among three nurses and any discrepancies should be identified and corrected prior to use of the MAR. The DON stated the first nurse would check the prior month physician order sheet against the new month physician order sheet. In addition, the DON stated the first nurse would review any new physician orders against the physician order sheet. The DON stated the current physician order sheet would then be compared to the current MAR. The DON stated the three nurses	F 514	F 514 The physician was notified by the Unit Manager on 6/01/12, regarding clarification for Depakote order for resident #82. A clarification order was received to continue Depakote 125mg at 2pm daily. The Unit Manager clarified order on Medication Administration record (MAR) and the licensed nurse administered the ordered dose of Depakote 125mg to resident # 82. The Director of Nursing (DON), Unit Managers and Staff Development Coordinator began in service education for licensed nurses on 6/19/12, regarding Medication administration including comparison of medication cards to physician orders, noting of new orders, monthly physician order reconciliation and a 24 hour chart check review to assure medication administration accuracy Current facility residents have the potential to be affected by the **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	6/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 06/01/2012

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F 514	Continued From page 30 doing the review would check the current physician order sheet against the current MAR. The DON stated the second nurse would check the current MAR against any corrections on the current physician order sheet. The DON stated the third nurse would place the current MAR on the medication book after checking the new MAR against the prior month MAR and physician order sheet. The DON stated the two nurses that checked the June 2012 physician order sheet and MAR for Resident #82 should have identified the wrong dose of Depakote. No explanation was given why a third check had not been done of the June physician order sheet and MAR of Resident #82 prior to placement of the MAR in the medication administration book.	F 514	alleged deficient practice. The DON and unit managers conducted an audit of current resident physician orders with comparison to prior month orders, telephone orders and MAR's to identify discrepancy in physician orders. Physician was notified regarding discrepancies identified and clarification orders were written as necessary. The pharmacy tech completed a facility audit on June 18-19, 2012 to verify accuracy of medication orders. The Director of Nursing (DON), Unit Managers and Staff Development Coordinator began in service education for licensed nurses on 6/19/12, regarding Medication administration including comparison of medication cards to physician orders, noting of new orders, monthly physician order reconciliation and a 24 hour chart check review to assure medication administration accuracy. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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