

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>345477</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>6/7/2012</b>
NAME OF PROVIDER OR SUPPLIER <b>THE OAKS AT SWEETEN CREEK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3864 SWEETEN CREEK RD ARDEN, NC</b>	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 514</b>	<p><b>483.75(1)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</b></p> <p>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 systematically organized.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record review, the facility failed to correctly transcribe a physician order to the Medication Administration Record for one (1) of ten (10) residents (Resident #105).</p> <p>The findings are:</p> <p>Resident #105 was admitted to the facility on 03/20/10 with end stage renal disease. She was discharged to the hospital on 05/29/12 and readmitted on 06/01/12. The most recent Minimum Data Set (MDS), dated 05/19/12, revealed the resident was cognitively intact and required extensive assistance with most activities of daily living. The MDS also revealed no significant weight gain or loss.</p> <p>On 06/06/12 at 12:48 PM, Resident #105 was interviewed. She stated she received a protein supplement every day. She stated the supplement tasted bad and sometimes she refused it.</p> <p>A review of the Medication Administration Record (MAR) from 05/22/12 through 05/28/12 revealed the following: "Medpass 120 cc fluid X4," with times listed for administration at 8 AM, noon, 5 PM, and 8 PM. On 05/29/12, Resident #105 was hospitalized.</p> <p>On 06/01/12, Resident #105 was readmitted to the facility. Further review of the MAR from 06/01/12 through 06/04/12 revealed the following: "Medpass 120 cc X4," with times listed for administration at 8 AM, noon, 5 PM, and 8 PM.</p> <p>On 06/07/12 at 12:20 PM, Licensed Nurse (LN) #3 was interviewed. She stated that the order on the MAR was for 120 cc of the protein supplement called Med Pass which she had administered to Resident #105 as indicated on the MAR during the above time periods.</p> <p>On 06/07/12 at 12:33, LN #4 was interviewed. She confirmed that she had administered 120 cc of the protein supplement to the resident as indicated on the MAR during the above time periods.</p> <p>On 06/07/12 at 12:36 PM, LN #5 was interviewed. She also confirmed that she had administered 120 cc of the protein supplement to the resident as indicated on the MAR during the above time periods.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 514</b>	<p>Continued From Page 1</p> <p>On 06/07/12 at 12:45 PM, LN #6 was interviewed. He also confirmed that she had administered 120 cc of the protein supplement to the resident as indicated on the MAR during the above time periods.</p> <p>A review of the physician orders revealed there was no order for administration of the protein supplement called Med Pass to Resident #105. However, there was a physician order written on 05/22/12 to limit fluid intake to 1000 cc per twenty-four hour period.</p> <p>On 06/07/12 at 3:15 PM, the Director of Nursing (DON) was interviewed. She stated that after the fluid intake order was written on 05/22/12, the Unit Manager and the Dietary Manager discussed with Resident #105 how she would like the 1000 cc of fluids to be spread throughout the day. One intervention was to provide the resident with 120 cc of fluid each time she received medications. The DON stated the Unit Manager transcribed that intervention onto the MAR to read "Medpass 120 cc fluid X4." She stated this was "poorly worded" and nurses read it as an order to administer the protein supplement called Med Pass. The DON stated the order would have been better written to read "120 cc free water with medications." She also stated that when the resident was readmitted, the physician wrote an order to resume all previous orders so the order was transcribed from the May MAR onto the June MAR, and nurses continued to administer the protein supplement. She stated the resident was not harmed by the protein supplement.</p> <p>On 06/07/12 at 3:32 PM, the Unit Manager (UM) was interviewed. She stated that the way she transcribed the order onto the May MAR may have been confusing to the medication nurses. She stated she should have transcribed the order to read "Limit fluids with each medication pass to 120 cc."</p>		

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PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  346477	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/07/2012
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NAME OF PROVIDER OR SUPPLIER  THE OAKS AT SWEETEN CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK RD ARDEN, NC 28704
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F 272 SS=B	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>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;                  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.</p>	F 272	<p>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.</p> <p>F-272</p> <ol style="list-style-type: none"> <li>1. Resident # 112 Care Area Assessment (CAA) summaries were corrected to include end of life information. Resident # 99 no longer resides in the facility.</li> <li>2. Facility Administrator/Facility Director of Clinical Services reviewed all current hospice residents to ensure that their CAA summaries include end of life information. The Regional Reimbursement Specialist re-educated the Facility Minimum Data Set (MDS) Nurse to ensure that residents receiving hospice services have CAA summaries that address end of life information.</li> <li>3. Facility Administrator/Facility Director of Clinical Services will conduct QI monitoring to ensure that residents receiving hospice care have CAA summaries that include end of life information. QI monitoring will be conducted 1 x weekly for 8 weeks and then 1 x monthly for 10 months.</li> </ol>	7-5-12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Verna Montie TITLE: Administrator (X6) DATE: 7-5-2012

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RECEIVED  
JUL 6 2012  
BY: ORU

Original Signature Date: 6-29-12

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F 272 Continued From page 1	<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and record review, the facility failed to include end of life information in any triggered Care Area Assessment summaries in Minimum Data Sets for two (2) of two (2) sampled residents receiving Hospice care. (Residents #99 and #112).</p> <p>The findings are:</p> <p>1. Resident #99 was admitted to the facility with diagnoses including dementia, sepsis, deep vein thrombosis of a lower extremity, and decubitus ulcer.</p> <p>A review of Resident #99's medical record revealed a physician's progress note dated 03/23/12. The note specified Resident #99's estimated six (6) months mortality risk was 50% or higher. The note documented the prognosis was poor and the resident was followed by Hospice.</p> <p>A Minimum Data Set (MDS) dated 03/29/12 specified Resident #99 was on Hospice care and triggered in the following areas: Cognitive loss/dementia, Visual, Urinary incontinence/indwelling catheter, Psychosocial well-being, Mood state, Activities, Nutritional status, Dehydration/fluid maintenance, Pressure ulcer, and Pain. A review of Care Area Assessment (CAA) summaries for these triggered areas revealed no mention of end of life care.</p>	F 272  272	4. Facility Administrator/Facility 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.

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F 272 Continued From page 2  
loss/dementia, Visual, Urinary incontinence/indwelling catheter, Psychosocial well-being, Mood state, Activities, Nutritional status, Dehydration/fluid maintenance, Pressure ulcer, and Pain. A review of Care Area Assessment (CAA) summaries for these triggered areas revealed no mention of end of life care.

F 272

An interview with the corporate MDS Specialist on 06/07/12 at 12:20 PM revealed the facility was between MDS nurses at present. She stated she was the acting MDS facility nurse until the newly hired MDS nurse started employment. She reviewed the CAA summaries and found no mention of end of life care. The MDS Specialist stated she expected the CAA summaries to state the resident was receiving end of life care.

2. Resident #112 was readmitted to the facility with diagnoses including dementia, chronic obstructive pulmonary disease, and Parkinson's disease.

A review of Resident #112's medical record revealed he was admitted to Hospice services 11/17/11.

A review of a comprehensive Minimum Data Set (MDS) assessment dated 11/12/11 revealed Resident #112 was on Hospice care and triggered for the following areas: Cognitive loss/dementia, Communication, Activities of daily living functional/rehabilitation potential, Urinary incontinence/indwelling catheter, Psychosocial well-being, Behavioral symptoms, Activities, Falls, Nutritional status, Dehydration/fluid maintenance,

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F 272	Continued From page 3  Dental care, Pressure ulcer, and Psychotropic drug use. A review of Care Area Assessment (CAA) summaries for these triggered areas revealed no mention of end of life care.  An interview with the corporate MDS Specialist on 06/07/12 at 11:30 AM revealed the facility was between MDS nurses at present. She stated she was the acting MDS facility nurse until the newly hired MDS nurse started employment. She reviewed the CAA summaries and found no mention of end of life care. The MDS Specialist stated she expected the CAA summaries to state the resident was receiving end of life care.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and medical record review, the facility failed to medicate one (1) of two (2) residents prior to a dressing change (Resident #22).  The findings are:  Resident #22 was admitted to the facility with diagnoses of hip fracture and anxiety disorder, among others. The most recent Minimum Data	F 309 F-309	<ol style="list-style-type: none"> <li>1. Resident #22 suffered no harm.</li> <li>2. Facility Director of Clinical Services/Nurse Manager reviewed all current residents requiring wound care to ensure that residents are being medicated per MD orders prior to wound dressing changes. Facility Director of Clinical Services/Nurse Manager re-educated all current nursing staff to ensure that they are medicating residents per MD orders prior to wound dressing changes.</li> <li>3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring to ensure that residents are being medicated per MD orders prior to wound dressing changes. QI monitoring will be conducted 5 x weekly for 8 weeks,</li> </ol>	7/5/12

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F 309	Continued From page 4 Set (MDS) dated 03/24/12 revealed the resident had severe cognitive impairment and required extensive to total assistance with activities of daily living. The MDS also revealed that during the assessment period Resident #22 received pain medications as needed and had vocal complaints of pain.  The resident's care plan, dated 06/24/12, addressed pain. Interventions included assessment for signs and symptoms of pain such as crying, facial grimacing, and pain complaints, use of a 1 to 10 scale to rate the intensity of the pain, and identification of the source of the pain. One intervention read "Administer medication per order and assess effectiveness."  On 06/07/12 at 7:55 AM, a dressing change was observed to the left heel of Resident #22. Nursing Assistant (NA) #4 removed the sock from the resident's left foot, and the resident responded with "Oww!" NA #4 stated she was sorry that it hurt. The Wound Care Nurse (WCN) entered the room and began to remove the old dressing. After the dressing was removed, the WCN asked the resident if she had any discomfort. Resident #22 stated no. The wound opening was observed to be approximately dime sized. The WCN stated at that time that the current measured depth was 0.3 centimeters. The WCN soaked a cotton tipped applicator in saline to clean the wound. When she inserted the applicator into the wound opening and rotated it, the resident winced and called out "Ohhh!" The WCN removed the applicator and asked the resident if the procedure hurt her. She responded "Yes," but moments later she stated that she was okay now. The WCN prepared a second cotton tipped applicator with	F 309	then 3 x weekly for 4 weeks, 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.		

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F 309	<p>Continued From page 5</p> <p>an antimicrobial wound gel, inserted it into the wound opening and rotated it. The resident did not cry out or wince. A gauze packing and top dressing were applied.</p> <p>On 06/07/12 at 8:15 AM, Resident #22 was interviewed. She stated that the dressing change was not too bad, but she stated that she cried out because it hurt when the nurse inserted the applicator. She stated that sometimes the nurse gave her pain meds before the dressing change but she could not remember if she had had pain meds that morning.</p> <p>On 06/07/12 at 8:19 AM, Licensed Nurse (LN) #1 was interviewed. She reviewed the Medication Administration Record and noted that the resident had an order to receive a narcotic analgesic, hydrocodone 5 mg with 325 mg of acetaminophen, scheduled for 8:00 AM. She stated the medication had not yet been administered. LN #1 stated that she normally gave the medication before the daily dressing change, but she had not had time to give the medication yet. She stated that sometimes the nursing staff checked with her before the dressing change to make sure the resident had had the medication, and sometimes they didn't. She stated no one had checked with her this morning.</p> <p>On 06/07/12 at 8:25 AM, the WCN was interviewed. She stated that usually NA #4 performed the dressing change, but on days when the wound care physician made rounds, she performed it. She stated when she performed it, it was usually middle to late morning and the resident had had her scheduled pain meds</p>	F 309	



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F 309	Continued From page 6 already. The WCN stated she had never seen the resident have a pain reaction until today. She stated that for a wound that deep she would usually check with the medication nurse to make sure the resident had received her scheduled narcotic analgesic.  On 06/07/12 at 8:37 AM, NA #4 was interviewed. She stated she usually performed the daily dressing change between 7:30 and 8:30 AM, but sometimes it was done later in the morning. She stated that the resident had never shown pain during the dressing change before today, but today she called out when she removed her sock. She stated she did not usually check with the medication nurse about pain meds because pain had not been a problem for the resident in the past.  On 06/07/12 at 11:09 AM, the Director of Nursing (DON) was interviewed. She stated that NA #4 should have alerted the WCN that the resident had a pain reaction when she removed her sock. She also stated that the WCN was correct to assess for pain when Resident #22 called out during the use of the cotton tipped applicator. But the DON stated that when the resident confirmed the pain, she should have checked to see if the resident had received her pain medication already. If not, the DON stated, the procedure could have been stopped if necessary until she received her medication. The DON stated she expected nurses to check to ensure pain medication had been given for a dressing change on a deep wound.	F 309	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312	

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F 312	<p>Continued From page 7</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review the facility failed to ensure facial hair was removed for one (1) of three (3) dependent sampled residents (Resident #64).</p> <p>The findings are:</p> <p>Resident #64 was admitted to the facility with diagnoses of diabetes, hyperlipidemia and Alzheimer's dementia. Review of Resident #64's most recent quarterly Minimum Data Set (MDS) dated 03/01/12 revealed she had long and short term memory loss and was impaired for daily decision making. The MDS further indicated she needed extensive assistance for all activities of daily living(ADL).</p> <p>Resident #64's care plan updated 03/01/12 revealed a care plan problem of inability to complete self care tasks independently and included an intervention to supervise and assist with ADL and hygiene AM and PM.</p> <p>An observation was made on 06/05/12 at 12:24 PM of Resident #64 in the dining room eating lunch. She was observed to have numerous chin hairs approximately two (2) inches long.</p> <p>An observation made on 06/06/12 at 10:07 PM of</p>	F 312	<p>F-312</p> <p>7/5/12</p> <ol style="list-style-type: none"> <li>1. Resident # 64's facial hair was immediately removed upon identification on 06-07-12.</li> <li>2. Facility Director of Clinical Services/Nurse Manager reviewed all current dependent residents for facial hair to ensure dependent residents requiring assistance with removal of facial hair had their facial hair removed, as applicable per their plans of care. Facility Director of Clinical Services/Nurse Manager re-educated all current nursing staff to ensure that nursing staff is assisting dependent residents with the removal of facial hair, as needed, with their activities of daily living and hygiene.</li> <li>3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring to ensure that dependent residents requiring removal of facial hair receive assistance as needed with activities of daily living and hygiene. QI monitoring will be conducted 5 x weekly for 8 weeks, then 3 x weekly for 4 weeks, then 1x monthly for 9 months.</li> <li>4. Facility Director of Clinical Services/Nurse Manager will report results of QI monitoring to the RM/QI Committee for continued compliance and/or revision.</li> </ol>

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NAME OF PROVIDER OR SUPPLIER  THE OAKS AT SWEETEN CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK RD ARDEN, NC 28704		
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F 312	<p>Continued From page 8</p> <p>Resident #64 in bed revealed her facial hairs were again observed as above.</p> <p>An interview was conducted on 06/07/12 at 8:39 AM with Nursing Assistant (NA) #1 who worked with the shower team. She stated that some of the activities of daily living tasks performed by the shower team for female residents included cleaning and trimming finger nails, removing chin hairs, applying lotion to their bodies and drying their hair.</p> <p>An observation was made on 06/07/12 at 8:43 AM of Resident #64 in the dining room. She continued to have numerous chin hairs that were approximately two (2) inches long.</p> <p>An interview was conducted on 06/07/12 at 10:03 AM with NA #2 who also worked with the shower team. NA #2 stated he was responsible for giving showers and providing ADL care for Resident #64 on Mondays and Thursdays. He stated he should have trimmed Resident #64's chin hairs during her showers.</p> <p>An interview was conducted on 06/07/12 at 10:10 AM with NA #3. She stated she had worked with Resident #64 this week. She stated the shower team usually trims or shaves resident's facial hair. She reported she had not tried to trim Resident #64's chin hairs this week and was unable to give an answer as to why it had not been done.</p> <p>An interview was conducted on 06/07/12 at 10:13 AM with Licensed Nurse #1 who worked with Resident #64. She stated NA staff should shave the female residents' chin hair. She said it was the responsibility of both the NAs who work on</p>	F 312		

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

PRINTED: 06/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345477	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/07/2012
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F 312 Continued From page 9  
the hall as well as the shower team staff. She revealed she had not noticed the resident's chin hair.

An interview was conducted on 06/07/12 at 10:21 AM with the Director of Nursing (DON). She said that staff should trim or shave resident facial hair. She stated it was both the NAs who work the halls as well as the shower team's responsibility to trim female facial hair when it is noticed.

F 312

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS

F 431 F-431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

- 7/5/12
1. Prescribed medication was immediately removed from Resident #77's room upon identification on 6-4-12. Resident #77 suffered no harm.
  2. Facility Director of Clinical Services/Nurse Manager conducted facility rounds to ensure that prescribed medications were not left unattended in residents' rooms. Facility Director of Clinical Services/Nurse Manager removed any identified prescribed medications from residents' rooms. Facility Director of Clinical Services/Nurse Manager re-educated all current licensed nursing staff on the Facility's Medication Administration Policy and Procedure to include that prescribed medications are not to be left unattended in residents' rooms.
  3. Facility Director of Clinical Services/Nurse Manager will conduct QI monitoring to ensure that

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F 431	<p>Continued From page 10</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to remove a prescribed medication from a resident's room for one (1) of twelve (12) sampled residents ( Resident #77).</p> <p>The findings are:</p> <p>Resident #77 was admitted to the facility with diagnoses of dementia, chronic obstructive pulmonary disease and osteoporosis. The most recent quarterly Minimum Data Set dated 05/09/12 assessed resident #77 as having long and short term memory loss and impaired for daily decision making.</p> <p>An observation was made on 06/04/12 at 8:24 PM of an unopened plastic vile of liquid medication used for nebulizer treatment sitting on Resident #77's over bed table. During this observation no licensed nursing staff was present in the room.</p> <p>An interview was conducted on 06/04/12 at 8:24 PM with Licensed Nurse (LN) #2. She reported that Resident #77 had refused her nebulizer treatment. She stated she had not noticed the medication in the resident's room. She stated the</p>	F 431	<p>prescribed medications are not left unattended in residents' rooms. QI monitoring will be conducted 5 x weekly for 8 weeks, then 3 x weekly for 4 weeks, and then 1 x monthly for 9 months.</p> <p>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.</p>	

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F 431	Continued From page 11 medication should not have been left in the room.	F 431		
	An interview was conducted on 06/05/12 at 11:12 AM with LN #1 who had worked the previous day with Resident #77. She stated Resident #77 had refused her 1:00 PM nebulizer treatment on 06/04/12. She stated the medication should not have been left at the bedside.			
	An interview was conducted on 06/06/12 at 3:30 PM with the Director of Nursing (DON). The DON stated that medication should never be left at the bedside.			