STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7156 WILSON, NC 27893

(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 000	INITIAL COMMENTS A recertification/complaint investigation survey was conducted from 07/23/12 through 07/26/12. The survey team returned to Avante at Wilson for an extended survey which took place from 08/01/12 through 08/03/12. 8/13/12 2567 ammended on 8/13/12 to correctly identify staff.	F 000	**This Plan of Correction (POC) constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by Federal and State Law as the facility's creditable allegation of compliance.**	
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to supervise a resident who was an unsafe smoker per the care plan for 1 of 1 (Resident #7) sampled residents. Findings include: Immediate jeopardy was identified on 08/01/12 at 10:40 AM. The immediate jeopardy began on 02/06/12 when resident #7 experienced new burns to his fingers, presumed to be the result of smoking, and was reassessed as a smoker now requiring supervision. The immediate jeopardy was removed on 08/03/12 at 10:02 AM when the facility demonstrated it had implemented its credible allegation of compliance. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy (D) so that audits could	F 282	**F-282 (483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN.** **A. <u>Corrective action taken for the affected resident.</u>** 1. For resident #7, on 7/25/2012 he was re-evaluated for smoking safety. Further, he was met with and informed of the facilities revised/updated resident safe smoking protocol. 2. Social Worker and Administrator personally reviewed revised protocol with Resident #7 on 7/25/12. Since he remains classified as a risk for independent smoking, he was informed that he continues to be classified as a supervised smoker. 3. Resident #7 signed the "Resident Smoking Acknowledgement" form on 7/25/2012.	8/3/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joel Magwire

TITLE: ADMINISTRATOR

(X6) DATE: 8/23/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 continue on the lock box where resident smoking materials were stored, on the supervisory status of residents on the smoking porch, and on the rooms of smoking residents. Findings include Resident #7 was admitted to the facility on 9/11/08 with cumulative diagnoses of quadriplegia, lack of coordination and contracture of the hand joints. Resident #7 was cognitively aware. Resident #7's quarterly Minimum Data Set (MDS) dated 5/18/12 indicated that Resident #7 was totally dependent on staff. Resident #7 had functional impairments on both sides of the body in the upper and lower extremities. A review of the Safe Smoking Assessment dated 2/6/12 showed that Resident #7 was an unsafe smoker and needed constant supervision while smoking. The assessment indicated that Resident #7 was unable to demonstrate the ability to light and smoke a cigarette or other smoking devices and was unable to demonstrate safe techniques for putting out matches or a lighter and disposing of ash. A review of the Care Plan updated 5/21/12 showed Resident #7 was at risk for injury related to smoking. Interventions included allowing for supervised smoking. In an observation on 7/24/12 at 3:16 PM, Resident #7 was taken out to the smoker's patio by a staff member. The staff member came back into the building and told the nurse that she had taken Resident #7 outside.	F 282	4. Cigarettes and ignition source of resident #7 secured and placed in locked safe box at Nursing station B and revised smoking safety protocol implemented. **B. <u>Corrective action taken for those residents having the potential to be affected by the deficient practice.</u>** 1. On 7/25/2012 a 100% audit of in-house residents was conducted to validate current smoker census. A total of 4 current residents (including resident #7) were validated as smokers. 2. The 3 residents other than resident # 7, were re-evaluated for smoking safety. Two of the three residents were added to the facility list of at risk for independent smoking requiring supervision. The 4th and last was determined to be an independent safe smoker. 3. These 3 remaining smokers were met with on 7/25/2012 by the Social Worker and the Administrator in a group setting. The revised/updated resident safe smoking protocol was presented to them and reason for implemented change. All three of the resident signed the Resident Smoking Acknowledgement form.	

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F 282	Continued From page 2 In an observation on 7/24/12 at 3:17 PM, Resident #7 was sitting alone on the patio in a reclined geri-chair with a lit cigarette in his left hand. There were no staff members outside providing supervision while he was smoking. In an interview on 7/24/12 at 3:35 PM the Director of Nursing (DON), indicated that Resident #7 should be supervised at all times while he was smoking. In an interview on 7/24/12 at 4:39 PM Physical Therapist #1 indicated that she had lit Resident #7's cigarette and then had come back into the building. She stated that there were no other staff members outside supervising Resident #7. She indicated that she had seen Resident #7 outside smoking unsupervised a few times, so she thought he was an unsupervised smoker. In an interview on 7/25/12 at 5:10 PM Nursing Assistant #1 indicated that although there may have been other residents outside with Resident #7 while he was smoking there were not always staff members outside supervising Resident #7 while he smoked. In an interview on 7/26/12 at 9:30 AM the Assistant DON (ADON) indicated that a resident in need of supervision should never be left to smoke alone. She stated that the resident could catch themselves on fire if they were not supervised. In an interview on 7/26/12 at 11:05 AM Restorative Aide #1 stated that sometimes Resident #7 was outside smoking by himself.	F 282	4. The care plans of the residents were updated 7/25/2012. 5. Cigarettes and ignition source of the three residents were secured and placed in locked safe box at Nursing station B and revised smoking safety protocol implemented. **C. <u>Measures Implemented and/or Systemic Changes made to ensure that deficient practices will not reoccur.</u>** 1. On 7/25/2012 a revised/updated practice for resident smokers was implemented. 2. From 7/25/2012 on, at risk resident smoker's cigarettes and ignition sources will not be allowed to be held in the custody of the resident. All such items shall be kept in a locked safe box at Nursing Station B per above listed revised smoking protocol. 3. New residents will continue to be evaluated for smoking safety and resident and RP informed of protocols regarding safety and storage of smoking materials at Nursing Station B. Resident smoking safety assessments shall continue to be performed upon initial admission, annually and on an as needed basis due to a change of condition.	

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F 282	Continued From page 3 In an interview on 7/26/12 at 2:40 PM the DON stated that it was her expectation that staff stay with a supervised smoker until the resident's cigarette was extinguished. The administrator was notified of the immediate jeopardy on 08/01/12 at 10:40 AM. The facility provided a credible allegation of compliance on 08/02/12 at 10:32 AM. The following interventions were put in place. · 07/25/12 Resident #7 was re-evaluated for smoking, was informed of the revised/updated safe smoking protocol, signed the Smoking Acknowledgement form, and had his smoking supplies placed in a lock box. · On 07/25/12 a 100% audit of in-house residents was conducted, and it was verified that a total of four current residents (including Resident #7) were smokers. All smoking residents were re-evaluated for smoking safety. Three of the residents were assessed as requiring supervision, and one was assessed as being an independent smoker. All smoking residents were informed of the revised/updated safe smoking protocol, their care plans and Kardexes were updated, and cigarettes and ignition sources for all smoking residents were secured in the lock box. On 07/25/12 it was determined that any smoking residents who refused to use the required protective equipment would only be able to smoke with one-on-one supervision. · On 07/25/12 and 07/26/12 all facility staff was in-serviced on the revised resident smoking protocol. Staff on vacation, weekend staff, or as	F 282	4. Resident smoking status shall be kept on the resident Kardex and updated by nursing management whenever a resident's smoking status changes. Status shall also be kept in the locked storage box on the inventory sheet. 5. Should an at risk resident smoker refuse to use necessary safety protective equipment, same shall be documented, care planned, information shared with responsible party and the resident will only smoke with one-on-one supervision. 6. For each resident smoker, an individualized smoker inventory tracking and safety requirement sheet was formulated and placed in the resident smoking lock box. Each time a resident requests a cigarette the staff will assure for arranging for resident safety while smoking while at the same time keep track of resident smoking item inventory. 7. Between 7/25 and 7/26, 2012 staff of all departments were in-serviced on the revised resident smoking protocol. Any staff member on vacation, leave or part-time/PRN staff during this period not in-serviced will not be allowed to begin work until in-serviced.	

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F 282	Continued From page 4 needed (PRN) staff were to be in-serviced prior to beginning work. · On 08/01/12 audits of the smoking lock box, the smoking patio, and the rooms of smoking residents began. These audits were implemented to make sure the staff and smoking residents were following policy regarding smoking supervision and the storing of resident smoking supplies. · Verification of the credible allegation was evidenced by review of in-service agendas and sign-in sheets, observance of employees being in-serviced on 08/01/12 through 08/03/12 who were not in attendance during previous in-services, and interviews with staff in which they verified attendance and summarized what they learned in the smoking in-services. Smoking residents were observed on the smoking patio, the lock box was observed, and the rooms of smoking residents were observed to make sure smoking supplies were not present. The revised/updated safe smoking policy was reviewed, care plans and Kardexes of smoking residents were reviewed to make sure the most current smoking status was documented, and facility audit sheets were reviewed. The immediate jeopardy at F282 was lifted on 08/03/12 at 10:02 AM.	F 282	8. Responsible party for each resident has been informed of change in smoking protocol. **D. <u>How the facility plans to monitor its performance to assure ongoing compliance is sustained.</u>** 1. Management will check the smoking lock box daily to assure that for those smokers at risk there are initials of the attendant who supervised the resident smoking. 2. Effective 8/1/2012, Members of the management team will randomly check the resident smoking porch two times a shift to observe resident smokers and assure for compliance with smoking protocol. This will continue for 30 days until supervised designated smoking protocol is implemented 9/1/2012. 3. Following 30-day notice to smokers, which was given 8/1/2012, designated resident smoking times for at-risk smokers will be implemented with staff assigned to distribute cigarettes and monitor resident smokers.	
F 314 SS=J	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	F 314		

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F 314	Continued From page 5 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, record review and staff interview, the facility failed to monitor and assess the resident's right foot for changes in condition. The facility also failed to document a decline in a blister to the resident's right foot resulting in an unstageable pressure ulcer which encompassed the entire heel for 1 of 8 sampled residents (Resident #118) who had pressure ulcers. Findings include: Immediate jeopardy was identified on August 1, 2012 at 10:40 AM. The immediate jeopardy began on July 4, 2012 and was removed on August 3, 2012 at 10:02 AM when the facility demonstrated it had implemented their credible allegation of compliance. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy (D) so that the facility could monitor the progress of the new interventions placed for assessment and documentation of pressure ulcers. Findings include: The facility's standing order treatments for skin conditions, last revised 07/10/08, described an unstageable pressure ulcer as eschar or necrotic tissue covering and preventing staging of the ulcer. Heels were to be floated using pillows,	F 314	4. Beginning 8/1/2012 for a period of 3 months, randomly on a weekly basis, management team member spot checks of at risk smoking resident rooms will be made to assure for compliance with smoking materials storage protocol in the locked storage box. 5. Monitoring logs from above checks will be presented at the monthly safety committee meeting for the next three months. 6. Results of Safety Committee findings and recommendations will be presented to the QA Committee for review and recommendations for a period of three month. E. <u>Date Corrective Action Completed:</u> Corrective action was achieved on 8/3/2012.	

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F 314	Continued From page 6 podus boot, or heel up cushions if area was located on the feet, heels or ankles. The physician, responsible party and the wound nurse were to be notified and treatment was to be initiated. Resident # 118 was re-admitted to the facility on 03/31/12. Cumulative diagnoses included congestive heart failure, pressure ulcers and Alzheimer's disease. Resident #118's Admission Minimum Data Set (MDS) assessment of 04/07/12 indicated she had long and short term memory problems as well as severely impaired decision making skills. She was noted to have verbal behaviors toward others. She required extensive assistance from staff for all activities of daily living. In the pressure ulcer section of the MDS, she was identified as being at risk for pressure ulcer development. She triggered in 8 areas according to the Care Area Assessment (CAA) which included pressure ulcer. The pressure ulcer CAA detail indicated she was at risk for development of pressure ulcers. A pressure ulcer risk evaluation was completed on 04/27/12 for Resident #118. She was identified as being at low risk for pressure ulcer development with a score of 19. Resident #118's Quarterly MDS of 06/20/12 indicated she had developed no pressure ulcers.	F 314	**F-314 (483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES.** **A. <u>Corrective action taken for the affected resident.</u>** 1. For resident #118, the assigned nurse for July 4th has been re-educated on facility protocol with respect to skin assessment, observation requirements, specific medical record documentation, and notification requirements to physician and RP 2. The involved shift nurse on 7/4/2012 has been assigned to take an educational course on Health Care Academy entitled "Pressure Ulcer Determination and Management". This course was completed on 8/1/2012. Resident physicians (including the wound care doctor) who evaluated the resident on 7/27/2012, have continued the same treatment for the resident as ordered on 7/5/2012 with the single exception being that the wound care nurse got an order on 7/9/2012 to put a dry protective dressing on the site. On 7/27/2012 the visiting wound doctor examined the resident and again continued the treatment orders and documented that the wound is healing. On 7/4/12 that was the only breakdown. On 7/23/12 one	8/3/12

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F 314	Continued From page 7 A 06/29/12 handwritten note on the back of the June 2012 weekly skin assessment (skin audit) record for Resident #118 noted no redness or open areas. Skin was warm, dry and intact. A nurse's note of 07/04/12 at 3:00 PM, written by Nurse #2, indicated Resident #118's family member had approached Nurse #2 about a blister on her right heel. Nurse #2 documented Resident #118 had a blister covering the back of her right heel. The blister remained intact and she indicated to the family member that the treatment nurse would be notified. Nurse #2 was interviewed on 07/26/12 at 11:10 AM. She stated when she observed Resident #118's right foot there was a whitish blister to the back of her right heel and she didn't notice anything on the bottom of the heel. She wasn't sure of the exact day. She stated she had asked Nurse #5 to assess the area and was told the heel was boggy and intact but felt "mushy" with no fluids noted underneath the skin. She stated it would have been written on the 24 hour report for the treatment nurse (Nurse #3) to assess and treat. Nurse #2 commented that she wrote it in the communication book for the treatment nurse as well. When questioned as to what happened when the treatment nurse was not in the facility, she responded it was the responsibility of the nurses to initiate treatment. Nurse #5 was interviewed via the telephone on 07/26/12 at 3:45 PM. She stated she was the	F 314	was identified on the other foot by the wound nurse while doing daily treatment. For the first occurrence the interventions initiated included frequent re-positioning, the use of Bunny Boots bi-laterally, heal floaters for elevation in bed. Further, at time of breakdown, resident was included in weekly IDT weight and wound committee discussions. **B. <u>Corrective action taken for those residents having the potential to be affected by the deficient practice.</u>** 1. Upon admission all residents are evaluated using a Braden to determine any resident who is at-risk for skin breakdown. All residents are again evaluated using the Braden scale every week for four weeks and quarterly thereafter. Therefore all patients are in this evaluation on at least a quarterly basis. In addition, since 2010, a weekly skin audit is completed by charge nurses on every in-house resident. Further, each day during resident's showers, bed baths, incontinent care and ADL care (clothes changing) nursing staff (licensed and unlicensed) observe residents for any skin integrity issues/changes. Any observed changes of condition are reported	

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F 314	Continued From page 8 weekend supervisor and had received a telephone call from Resident #118's family asking about the appearance of Resident #118's right heel. She wasn't sure of the exact day but she went down to her room to look at the area. Nurse #5 stated there was a boggy discolored area noted to the bottom of the right heel and a dark discolored area to the ankle. She stated the area had been painted with betadine so was discolored from the stain of the betadine but the area was very boggy and red. Nurse #5 stated she really did not remember the exact appearance as it had been several weeks. She added that there was no protection in place so she obtained bunny boots for both of her feet as she was wearing only socks in bed. The 24 hour report contained an unsigned notation dated 07/04/12 that the wound nurse was to check a blister to the right heel of Resident #118 due to a family concern. A telephone interview was conducted with Nurse #3 on 08/07/12 at 9:36 AM to clarify the use of the communication book. She stated there were 2 books one for each wing of the facility. She stated Nurse #2 did make an entry on 07/04/12 at 2:30 PM that there was a blister to Resident #118's left heel which she stated was incorrect as it was the right heel. She stated then someone else wrote beside it "bottom of right foot". Nurse #3 stated that was the only entry in the communication book for Resident #118. Nurse #3 stated that she reviewed the book on a daily basis when she was in the facility.	F 314	to the charge nurse who assesses change, calls physician to secure any needed orders for resident care and treatment. Finally, the charge nurse documents the skin integrity changes in the Wound Treatment Communication Book for the wound nurse to follow-up. If wound nurse not scheduled, it is her designee who follows-up. Regarding implementation of preventive measures/interventions, they include the following: a) the use of Bunny Boots, b) heal floaters, c) increased frequency of repositioning or turn schedule, d) use of wedge pillows, e) RD consult, and f) use of specialty mattresses. Interventions are implemented as indicated on a case by case basis as listed in facility clinical standing orders for treatment. The licensed nurse will continue to document on the Kardex what interventions are in place for staff awareness to minimize potential risk if skin breakdown or further breakdown. Care plan will continue to be updated to include interventions. Interventions will be discussed and modified by the IDT team at the weight and wound weekly meeting. Further daily identified changes will be discussed each day at the morning clinical scrub meeting by the IDT.	

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F 314	Continued From page 9 On 07/05/12 another unsigned note was written on the 24 hour report that indicated the blister to Resident #118's right heel was "unpopped" and was being painted with betadine. The wound was to be left open to air and the heels were to be floated. It was also noted to notify the wound nurse. A treatment record for July 2012 for Resident #118 included a treatment of painting the right heel blisters with betadine and to float the heels. There were initials noted on 07/05/12, 07/07/12 and 07/08/12. On 07/09/12 the treatment was changed by the treatment nurse (Nurse #3) to paint the right heel including the blisters with betadine, apply a [brand name gauze] and wrap with rolled gauze daily. The date blocks had initials noted for all of the days from 07/09/12 through 07/31/12. During a telephone interview with Nurse #4, on 07/26/12 at 4:07 PM, she stated she received the information about Resident #118's right heel during the morning report on 07/05/12. She had observed the area to the right heel on 07/05/12 and there was a clear fluid filled blister to the right outer ankle bone and the bottom part of the heel was soft and black. She stated Resident #118 was wearing socks so she elevated her foot. Nurse #4 stated that was all she remembered. A telephone interview was conduct with Nurse #5 on 07/26/12 at 3:45 PM. She stated she wasn't sure which day she observed Resident #118's	F 314	2. The Director of Nursing and the Wound Care Nurse and Nursing Management Team on 8/1 and 8/2 conducted a mandatory in-service training for the licensed and unlicensed nursing staff on facility protocol regarding resident skin assessment, observation requirements, specific medical record documentation, and notification requirements to physician and RP 3. On 8/1 and 8/2, 2012 working licensed nursing staff completed an educational course on Health Care Academy entitled "Pressure Ulcer Determination and Management". Any licensed nurse not scheduled, on vacation, part-time/PRN staff, will not be allowed to work an assignment until they have completed the course. C. **Measures Implemented and/or Systemic Changes made to ensure that deficient practices will not reoccur.** 1. Facility Wound Care Assessment and Documentation protocol was updated 8/1/2012. 2. The Facility Standing Orders for Treatments for all skin change(s) of conditions identified during resident care and assessment was updated on 7/30/12.	

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AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7156 WILSON, NC 27893

(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 314	Continued From page 10 heel. She reported there was a boggy discolored area noted to the bottom of the right heel and a dark discolored area to the ankle. A physician's telephone order of 07/05/12 for Resident #118 indicated to paint the right heel blister with betadine, float her heels and refer to the wound nurse. A physician's progress note from Resident #118's physician dated 07/06/12 indicated the heel blisters were from ill fitting shoes. There was no mention of any assessment of the blisters. A weekly skin assessment sheet (skin audit) (completed by Nurse #2) dated 07/06/12 for Resident #118 indicated the blister to the right heel was intact. There was no other description of the area. Nurse # 2 was interviewed regarding the 07/06/12 skin audit on 07/26/12 at 11:10 AM. She stated when she observed Resident #118's right foot there was a whitish blister to the back of her right heel and she didn't notice anything on the bottom of the heel. The weekly summary for Resident #118 (completed by Nurse #11), dated 07/06/12, indicated no wounds but the skin turgor to the right heel was noted to be mushy.	F 314	3. On 8/1 and 8/2, 2012 the Director of Nursing and the Wound Care Nurse and Nursing Management Team conducted a mandatory in-service training for the nursing staff (licensed and unlicensed) on facility protocol regarding resident skin assessment, observation requirements, specific medical record documentation, and notification requirements to physician and RP. Any licensed nurse not scheduled, on vacation, part-time/PRN staff, will not be allowed to work an assignment until they have completed the course. 4. On 8/1 and 8/2, 2012 working licensed nursing staff completed an educational course on Health Care Academy entitled "Pressure Ulcer Determination and Management". Any licensed nurse not scheduled, on vacation, part-time/PRN staff, will not be allowed to work an assignment until they have completed the course. 5. On 8/1/2012 the DON revised the Supervisor Shift report to now include assessment of any new skin integrity issues that are identified which will be obtained from their checking the daily body audit sheets and daily shower logs.	

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F 314	Continued From page 11 A telephone interview was conducted with Nurse #11 on 08/06/12 at 3:40 PM. She stated she did not remember what Resident #118's right heel had looked like when she completed the summary of 07/06/12. She stated if she checked mushy the heel would have been soft. When questioned if the mushy heel should be reported to anyone, she stated she usually would monitor the area and if it changed she would notify the physician. Nurse #11 commented that she would have written it in the communication book for the treatment nurse but she was not sure if she did or not as it had been a while. She added that the area did start out as a blister but that was all she was able to report. An unsigned note was written on the 24 hour report for 07/07/12 that indicated the dressing to the heel was done by the supervisor (Nurse #5) who reported the heel as being boggy feeling. Nurse #5 was interviewed via telephone on 07/26/12 at 3:45 PM. She stated there was a boggy discolored area noted to the bottom of the right heel and a dark discolored area to the right ankle. She stated the area had been painted with betadine so was discolored from the stain of the betadine but the area was very boggy and red. An unsigned note for 07/08/12 was written on the 24 hour report that indicated heel floaters had been applied for boggy heels and the blister remained to Resident #118's right heel.	F 314	**D. How the facility plans to monitor its performance to assure ongoing compliance is sustained.** 1. The facility will continue its in-place system of daily resident body skin audits by charge nurses looking for any skin integrity change of condition(s). The new random audits by shift supervisor's implemented 8/2/2012 will validate the accuracy of body audits for skin integrity or change. 2. Effective 8/2/2012 on a daily basis, each nurse supervisor will, on the day and evening shifts, conduct a random blind audit of 3 of the charge nurse daily body skin audits to confirm accuracy of documented skin integrity for the day. This will occur daily for a period of one month after which practice will continue 5 times a week for a period of two months. 3. Daily body skin audits and supervisor blind audits will be reviewed by the DON or ADON on a daily basis for the duration of the monitoring period. This will continue to be a part of the daily clinical scrub board review.	

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F 314	Continued From page 12 A physician's telephone order of 07/09/12 for Resident #118 indicated to paint the right heel including the blister with betadine, apply [brand name pad] and foam then wrap with [brand name gauze] daily. Bunny boot only to right foot, no shoe to be placed, and keep heels floated when in bed. According to the weekly pressure sore record for Resident #118, a DTI (deep tissue injury) to the right heel had developed in house on 07/05/12. On 07/09/12 the area was described as 100% necrosis measuring 5.6 centimeters x 10.2 centimeters. At the bottom of the record, it was noted that she was receiving a multivitamin and bunny boots as well as heel floaters were to be used. A wound care note from Nurse #3 of 07/09/12 indicated there was an intact fluid filled blister noted to the lateral side of the right heel. In addition to the blister, there was "intact dark maroon colored skin on the bottom of heel." The physician and the family were notified of the wounds. Heel floater and bunny boots were in place. Nurse #3 was interviewed at 3:15 PM on 07/26/12. Nurse #3 stated when she first assessed the area on 07/09/12, there was a fluid filled blister noted to the outer right ankle and not the back of the heel. She stated she did not see it the day it was discovered as she was on vacation and did not assess it until 07/09/12 when she came back to work. Nurse #3 stated the hall	F 314	4. Effective 8/2/2012 each Monday thru Friday the DON or ADON or Wound Care Nurse shall review all physician orders written within the last 24 hours to identify any new orders for residents regarding skin treatment. For each identified new order or order change a member of the nurse management team shall review the resident's record to assure that order was implemented and resident nurse documented appropriately in the resident's chart that resident assessment or reassessment of skin integrity. A flow audit sheet is being used track order changes. 5. For the next three month period, the results of the above audits shall be presented to the monthly Quality Assurance Committee meeting for compliance monitoring and any audit modification directives. **F. Date Corrective Action Completed:** Corrective action was achieved on 8/3/2012.	

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F 314	Continued From page 13 nurses had been painting the blister with betadine during the time period from 07/05/12 through 07/08/12. Nurse #3 added that the hall nurses were responsible for treatments when she was not in the building. A nurse's note of 07/09/12 at 11:45 AM indicated there was a blister to the lateral side of Resident #118's right heel which was intact and the bottom of the right heel was maroon in color. Bunny boots and heel floaters remained in place. A weekly skin assessment (skin audit) sheet dated 07/13/12 for Resident #118 indicated there was a blister to the right heel and the heel was boggy. It was noted that there was an area to the left ankle but there was no description of the area. The wound nurse was notified. An interview regarding Resident #118's left foot was conducted with Nurse #2 on 08/02/12 at 10:30 AM. She stated the area to her left outer ankle was reddened but intact when she saw it on 07/13/12. She stated it looked like redness from pressure. The weekly summary for Resident #118, dated 07/13/12, indicated there was a wound to the left heel. It was noted that the color to the right heel was normal and the color to the left heel was abnormal. There was a check mark noted for the turgor of the left heel indicating it was mushy. There was a check mark indicating turgor to the right heel was firm.	F 314		

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F 314	Continued From page 14 A telephone interview was conducted on 08/06/12 at 2:40PM with Nurse #2 to clarify the information that she provided on the weekly summary and the weekly skin assessment (skin audit) of 07/13/12. She stated she had written the wrong heel on the weekly summary, that it was actually the right heel that was mushy and soft, not the left. She also stated there were no other reddened or open areas other than the one on the right heel. She stated there was the small reddened area to the outer left ankle with skin intact as she had mentioned on the weekly skin assessment form. According to the weekly pressure sore record for Resident #118, a DTI (deep tissue injury) to the right heel remained 100% necrotic and measured 5.8 centimeters x 10.2 centimeters on 07/16/12. A wound care note from Nurse #3 of 07/16/12 indicated the fluid filled blister was intact to the lateral side of the right heel with intact dark maroon colored skin on the bottom of the heel. The note also indicated heel floater and bunny boots were in place. A wound care note from Nurse #3 of 07/17/12 indicated the fluid filled blister was still intact on the lateral side of the right heel with intact dark maroon colored skin on the bottom of the heel. Heel floater and bunny boots were in place. A note from the registered dietician (RD) of	F 314		

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F 314	Continued From page 15 07/18/12 indicated Resident #118 had a deep tissue injury (DTI) to the right heel. The note indicated she was on a high calorie/high protein diet with variable intake of 25% - 75% of breakfast and lunch and 0-25% for dinner. Megace (an appetite stimulant) was ordered on 07/14/12. Her estimated protein need was 75 gram daily and the RD recommended addition of medpass 120 milliliters twice daily to provide 480 kilocalories and 20 gram protein daily. It was noted that Resident #118 had lost 4% of her weight over the past month. A wound care note from Nurse #3 of 07/18/12 indicated the registered dietician had been consulted and recommendations were approved for medpass 120 milliliters twice daily and to continue the high protein/high calorie diet. Resident #118 was also receiving a multivitamin daily. A weekly skin assessment sheet dated 07/20/12 for Resident #118 indicated the blister remained to the right heel, the heel was boggy and there was a dime size area to the left ankle. Bunny boots were applied to both feet. The weekly summary for Resident #118, dated 07/20/12, indicated she had a blister to the right heel and an area to the left ankle. A telephone interview was conducted on 08/06/12 at 2:40PM with Nurse #2 to clarify the weekly skin assessment of 07/20/12. She stated she had to	F 314		

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F 314	Continued From page 16 undress Resident #118 to perform her audit. She stated when she looked at her there were no reddened areas to the inner left heel. Nurse #2 stated she did have the reddened dime sized area to the left outer ankle. A progress note from the weight and wound meeting of 07/20/12 indicated that the deep tissue injury (DTI) remained on the right heel, the blister had erupted and the right heel remained dark maroon in color with a slight increase in size since last week. According to this note, the wound measured 5.8 centimeters x 10.2 centimeters. Resident #118's care plan, last updated on 07/23/12, identified a problem with her being at risk for development of pressure ulcers related to immobility and incontinence. On 07/05/12 it was noted that she had developed an unstageable pressure ulcer to her right heel. Included in the intervention section was to obtain weekly skin checks and provide incontinent care. A problem with a deficit in activities of daily living (ADL) was also identified. Interventions included to observe for redness, open areas, scratches, cuts, bruises during care and report any changes to the nurse. The treatment record for July 2012 included a new treatment as of 07/23/12 to the left heel. The left heel and left lateral ankle were to be painted with skin prep daily. There were initials noted in all of the date blocks.	F 314		

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F 314	Continued From page 17 Nurse #3 was interviewed about the area to the left heel and ankle at 3:15 PM on 07/26/12. She reported that Resident #118 had a DTI to her left heel that she was painting with skin prep. She commented that the area was discovered as a DTI on 07/23/12. The left outer ankle area was discovered on 07/23/12 as well and was a stage 1. The weekly pressure sore record for Resident #118 noted the formation of a DTI with 100% necrosis to the left heel discovered on 07/23/12. The left heel DTI measured 2 centimeters x 2 centimeters. The weekly pressure sore record for Resident #118 noted a stage 1 to the left ankle was discovered on 07/23/12. The area measured 2.2 centimeters x 2.2 centimeters. A physician's telephone order of 07/23/12 indicated to paint Resident #118's left heel and left lateral ankle with skin prep daily. The bunny boots were to be placed on at all times except during care and heels were to be floated on heel floats at all times when in bed. Resident #118 was observed in a chair with her eyes closed on 07/24/12 at 11:00 AM. There were heel protectors (bunny boots) noted to both feet. Resident #118 was observed reclined in a chair	F 314		

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F 314	Continued From page 18 on 07/25/12 at 11:00 AM. She had plaid heel protectors (bunny boots) in place to both feet. It was noted that she had a dressing to her right foot. Resident #118 was observed in bed with her eyes closed on 07/26/12 at 9:45 AM. Her feet were noted to be directly on the mattress with heel protectors (bunny boots) bilaterally. There were no heel floaters noted. An observation of a bed bath being provided by Nurse Aide #5 (NA#5) was conducted on 07/26/12 beginning at 10:15 AM. Resident #118 was positioned on her left side in her low bed. There were no pillows or floating devices noted underneath her feet. Her bunny boots were in place bilaterally but they had become displaced and were positioned above her ankles. There was a dressing noted to her right foot. There was no dressing on her left foot. She was noted to have an approximate 3 centimeter x 3 centimeter area of bright red skin with an approximate 1 centimeter by 1 centimeter dark gray center to the innermost part of her left heel. There was a dime sized bright red intact tissue area noted to her left outer ankle bone. It was also noted that she had a bright dark reddened area to her sacrum which measured approximately 1 centimeter x 1 centimeter. The nurse aide (NA#2) who worked with Resident #118 on 07/04/12 was interviewed on 07/26/12 at 8:40 AM. She stated she had worked with Resident #118 prior to the development of	F 314		

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F 314	Continued From page 19 pressure areas to her feet. NA#2 stated she wore shoes that fitted fine up until the pressure areas developed then she wore either socks or had bare feet. She stated at times Resident #118 would get agitated and kick the shoes off as they were the type with one Velcro strap across the top of her foot. NA#2 stated she did not wear bunny boots or any type of heel protectors prior to the development of the pressure areas to her feet. She stated Resident #118 did not have any open areas when she worked with her. Nurse Aide #5 (NA# 5) was interviewed at 11:25 AM on 07/26/12. She stated this was the first day she had worked with Resident #118. NA#5 stated she had talked with NA#7 to see what types of care Resident #118 needed. NA#5 was unable to answer any questions about her skin. When questioned about the reddened sacral area, she stated she felt it was from the way she was positioned in bed. She stated if she saw any red areas she would report them to the hall nurse. NA#5 commented Resident #118 did not eat much of her breakfast but did drink the fluids that were on her tray. NA#5 added that she would either look at the resident's Kardex (care card) or ask another aide about her care needs. NA#6 was interviewed on 07/26/12 at 2:20 PM. She stated Resident #118 did not like to be bothered and she had worked with her a lot. She stated she had declined lately and was not as active. She stated she always wore socks when in bed per her family's request. NA# 6 stated when she worked with her she did not notice any blisters or open skin areas anywhere. NA#6	F 314		

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F 314	Continued From page 20 stated when she dressed her; she usually placed sketcher-type shoes which had one Velcro strap that was placed over the top of her foot. She stated Resident# 118 had a habit of kicking them off. When questioned about the fit of her shoes, NA#6 stated at one time she had a pair of shoes that were too tight and she had reported that to the family. She stated the family brought in another pair of shoes that fitted fine. NA#6 commented that she thought the family had taken the improperly fitting pair of shoes home. NA#6 added that Resident #118 did not wear any heel protection when she was in bed prior to the development of her pressure area. NA#6 stated if she saw any changes in her skin she would report them to the nurse. Nurse #7 was interviewed on 07/25/12 at 3:45 PM. She stated there had been issues with medication changes for Resident #118 in efforts to control behaviors. She stated since the medication changes, Resident #118 had been very lethargic and spent more time in bed. She stated Resident #118 had developed a blister to her right foot due to shoes being too tight. Nurse #7 stated the family wanted her to wear shoes but they were too small. Since the blister was discovered, she had not worn shoes. NA#3 had been assigned to Resident #118 on second shift on 07/03/12 and was interviewed on 07/26/12 at 2:00 PM. She stated she had worked with Resident #118 prior to the development of open areas to her feet. She stated she did not feed her that day as she had an orientee (NA#7) working with her. NA#3 commented that	F 314		

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F 314	Continued From page 21 Resident #118 had not been as alert as she used to be. She stated she did have one bunny boot but she was not sure which foot it was on, she thought it may have been on the left foot. She commented that was all that she remembered. Wound care was observed on 07/26/12 at 3:00 PM. Nurse #3 began to remove the adhered dressing from the outer right ankle wound using wound cleanser to moisten it as she removed it. Upon observation of Resident #118's right foot, she was noted to have dark black leathery appearing skin which extended from the outer ankle downward encompassing the bottom of the heel and partially up the back of the heel and upward onto the other side of her inner foot to the ankle. There was an approximate 3 centimeter x 3 centimeter reddened open area noted over the right outer ankle within the eschar tissue. Upon observation of the back part of the heel, it was noted that the eschar encompassed both sides of the back of the heel but the center most part was intact and normal in appearance. Nurse #3 painted the area with betadine and applied a thick gauze pad and wrapped it with rolled gauze. She painted the inner left heel with skin prep. The area to the innermost left heel was approximately 3 centimeters x 3 centimeters of reddened skin with an approximate 1 centimeter x 1 centimeter dark gray center. Nurse #3 was interviewed immediately after the wound care was completed at 3:15 PM on 07/26/12. Nurse #3 stated the area had first started out with a blister noted to the outer right ankle which had since erupted and the entire	F 314		

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F 314	Continued From page 22 area was 100% eschar which extended from the inner right ankle area down under the bottom of the foot and up the other side of the foot to the ankle bone. She commented she did not expect to find any pressure ulcer at the unstageable stage. She reported when she first saw the right heel, there was a DTI to the bottom of the heel and a blister to the right ankle. Nurse #3 indicated Resident #118 had suffered a decline in her overall condition lately and felt her nutrition status led to the formation of the unstageable area to the right foot. Nurse #3 commented that the wound physician had not seen Resident #118 but was scheduled to see her on 07/27/12. When questioned if her primary care physician had assessed the ulcers, she responded that he had not. The Director of Nurses (DON) was interviewed on 07/26/12 at 4:30 PM. She stated when she originally found out about the right heel it was thought the fluid filled blister had formed from wearing shoes that were too narrow and fitted improperly. The DON stated after 3 or 4 days had passed, the bottom part of the heel was blackened and she no longer felt the area was caused by ill-fitting shoes. She added that the left heel had begun to breakdown as well. The DON stated Resident #118 had not been wearing shoes since the original blister was discovered. She stated staff were painting the right heel with betadine as the treatment nurse was on vacation the week the blister was discovered. The DON commented that staff should have been monitoring as well as assessing the blister daily. She stated she expected staff to document a description of the blister on a daily basis. She	F 314		

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	345063	A. BUILDING _____ B. WING _____	08/03/2012

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F 314	Continued From page 23 added staff should have been assessing both feet for any changes in the appearance of the blister or development of new areas. She also commented any changes should have been documented and reported to the physician. She stated pressure ulcers were discussed in the morning meetings. The DON reported the blackened area to Resident #118's heel was preventable and should not have been discovered at the unstageable stage. She also stated she would expect to see heel protection added to the resident's Kardex so direct care staff knew to provide them. The DON reported it was not necessary to wait for the dietician to recommend the addition of Vitamin C and Zinc Sulfate for wound healing. The weekly summary for Resident #118, dated 07/27/12, noted there was a blister to the right heel. It was noted that skin turgor to the left heel was firm and the right heel was mushy (soft). The left heel was noted to have normal color and the right heel had abnormal color. There were no other descriptions noted. The weekly skin assessment record for Resident #118, dated 07/27/12, indicated there was an area to the right heel which remained with no drainage and a small unopened area to the left ankle. Bunny boots were in place to both feet. A telephone interview was conducted on 08/06/12 at 2:40 PM with Nurse #2 to clarify the 07/27/12 weekly skin assessment. She stated Resident #118 was undressed and she performed the skin	F 314		

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F 314	Continued From page 24 audit. She stated she did not notice any reddened areas to the sacrum. When questioned about redness to the inner left heel, she stated she did not notice any when she did her assessment. A wound care specialist initial evaluation of 07/28/12 for Resident #118 revealed she had an "unstageable (due to necrosis) of the right heel of unknown days duration. There is no exudate associated with the wound." The etiology was noted as pressure and measured 5.5 centimeters by 15 centimeters with 100% thick adherent black necrotic tissue. The left medial heel was described as an unstageable DTI with etiology noted as pressure. The wound was measured to be 0.5 centimeters by 1.3 centimeters. It was noted there was no albumin level available and none was ordered. It was also noted that there was no prealbumin level available but one was ordered. A note from the RD of 07/31/12 indicated the DTI to Resident #118's right heel continued. Her diet was to be downgraded to puree and staff were feeding all meals. Her intake varied and the high protein/high calorie diet with the supplement was to be continued. According to Resident #118's treatment record for July 2012, the left outer ankle stage 1 had resolved as of 07/31/12. Resident #118 was observed in bed positioned on	F 314		

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F 314	Continued From page 25 her back on 08/01/12 at 11:30 AM. NA#2 stated she was assigned to Resident #118 today. She uncovered her and it was noted there was a pillow underneath her upper thighs and knees but her heels were resting directly on the mattress. Bunny boots were in place to both feet. When questioned about positioning, NA#2 stated there was a blue wedge cushion that she thought was hers. She pointed to the cushion that was on the floor between the closet and the wall. She left the room. During an observation of Resident #118 on 08/01/12 at 4:00 PM, she was noted to be in bed positioned on her back with no pillows underneath her feet. Bunny boots were in place to both feet. NA# 9 was providing personal care to Resident #118 at 4:15 PM on 08/01/12. Upon observation she was noted to have bunny boots in place but no positioning pillows to her feet to float her heels off the bed. NA#9 was interviewed about Resident #118 on 08/01/12 at 4:30 PM. She stated she was assigned to Resident #118 and was familiar with her. NA#9 reported that Resident #118 had no positioning cushions for her feet that she was aware of. She did state she wore bunny boots as protection to prevent skin breakdown to her feet when they pressed against the footboard. She stated at present she did not have any open areas that she was aware of. When questioned as to positioning for Resident #118, NA#9 stated she turns her every 2 hours when she was in bed	F 314		

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F 314	Continued From page 26	F 314		

and used pillows behind her back when she turned her. NA#9 reported that Resident #118 would not reposition herself in bed. NA#9 described the heel float cushions as cushions with wings up each side to keep the heels floated off the bed. She commented that those type cushions came from the therapy department. She added that Resident #118 did not have one of those pillows. NA#9 commented that she always looked at the Kardex (care card) for her residents so she would know what specifics were needed for care.

During an interview with the occupational therapist (OT) on 08/02/12 at 8:45 AM, she stated she had been working with Resident #118 on positioning in her wheelchair. She stated the nurses would make the determination for bed positioning as she did not usually get referrals for positioning for pressure ulcers. She added that there were positioning cushions available for floating heels.

During another observation of Resident #118 on 08/02/12 at 8:55AM, she was noted in bed with a thick blue cushion underneath her knees with her feet floated off the bed. Bunny boots were in place to both feet.

During an interview with Nurse #3 on 08/02/12 at 9:00 AM, she stated the heel float cushions were kept in the barn and anyone had access to them. She added that the heel float cushions would not be appropriate for Resident #118 as she had contracted knees and the cushions would actually

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F 314	Continued From page 27 cause her heels to stay pressed onto the mattress. Nurse #3 stated staff had been instructed to elevate her feet on pillows. She stated pressure ulcer risk evaluations were completed quarterly for the residents and Resident #118 was due for one. She stated when she mentioned heel floats in her notes she was referring to pillows. The Assistant Director of Nurses (ADON) was interviewed on 08/02/12 at 11:00 AM. She stated the 24 hour report was a communication tool between the nurses and administration. She stated any concerns, falls, follow-ups or changes in condition were written on the report. The ADON stated it was not mandatory for nurses to document but it was encouraged. She stated the 24 hour report was reviewed daily by the DON as well as ADON and the supervisors. She added that the pink copies of the telephone orders were given to Nurse #3 for her to review on a daily basis. A nurse's note of 08/02/12 at 12:30 PM from Nurse #3 found in Resident #118's chart indicated NA#2 had reported an open area to the sacrum. It was noted that there was a reddened but blanchable (condition where redness should fade when skin touched and released) area with a dime sized open wound that measured 1.6 centimeters x 0.5 centimeters x 0.1 centimeters. The periwound was red but blanchable. A physician's telephone order of 08/02/12 for Resident #118 indicated to clean the sacral area	F 314		

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F 314	Continued From page 28 with wound cleanser and paint with skin prep, apply barrier cream and cover with duoderm every 3 days. During an interview with Nurse #3 on 08/03/12 at 9:00 AM, she stated NA#2 had reported the stage 2 to Resident #118's sacrum yesterday. She stated she assessed it and obtained orders to begin treatment. When questioned if NA#5 had reported the area last week, she stated she had not. Upon review of Resident #118's care card Kardex on 08/03/12 at 9:00 AM, it was noted that there was no mention of any pressure reduction intervention for Resident #118. In the skin care section it was noted "q round (every round)". The block for wounds was blank. During an interview with the DON, on 08/03/12 at 9:10AM, she stated NA#5 did not have the training to make a decision as to what would have caused the redness to Resident #118's sacral area. She stated she should have reported it when she saw it last week during the bed bath observation. When questioned about the care card Kardex, she responded she would update it immediately. A telephone interview was conducted with Nurse #3 on 08/07/12 at 9:00 AM. She stated she had two communication books, one for each wing of the facility. She reported she reviewed them daily for any issues that the hall nurses had noted.	F 314		

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F 314	Continued From page 29 She commented the only note regarding Resident #118 was on 07/04/12 regarding the blister to the right foot. Nurse #3 added that she was out of the facility at that time and looked at the book upon her return on 07/09/12. The administrator was notified of the immediate jeopardy on 08/01/12 at 10:40 AM. The facility provided a credible allegation of compliance on 08/02/12. The following interventions were implemented: · Nurse #2 was interviewed on 08/02/12 at 10:30 AM and stated she had completed the online Pressure Ulcer course. She was able to report expectations for skin assessments, documentation and notification requirements. · The wound care specialist assessed Resident #118 on 07/28/12. The treatment per the specialist was to apply skin prep to the unstageable wounds of the right foot and the left medial heel. · Direct care staff as well as licensed nursing staff were interviewed on 08/02/12. All of the staff interviewed were able to report attendance of a pressure ulcer inservice over the last 2 days. Direct care staff reported they had been instructed to report any changes in a resident's skin to the hall nurse no matter how insignificant it might appear. Licensed nursing staff reported being required to take an online computer course on pressure ulcers before being allowed to work. Off duty staff were observed coming into the facility taking the computer courses on 08/03/12. · Resident #118 was observed in bed with a large thick blue cushion noted underneath her	F 314		

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F 314	Continued From page 30 knees floating her feet off the bed on 08/03/12 at 9:00 AM. · Resident #118's care card Kardex had not been updated as of 9:00 AM on 08/03/12. Upon discussion with the DON, she immediately updated the Kardex to include pressure ulcer prevention interventions. · Random skin audits were completed on 3 residents beginning on 08/02/12. According to the treatment nurse on 08/03/12 at 8:30 AM, the supervisors were conducting look behind skin audits and making comparisons with the one the hall nurse had completed. She stated if the comparison skin audit identified any discrepancies, the nurse who completed the original skin audit would be re-educated as to documentation needed. She provided copies of the audits that had been completed and it was noted that the DON had reviewed the skin audits of 08/02/12 on 08/03/12. · Resident #118's care plan had been updated on 08/03/12 to include the left medial heel unstageable DTI pressure ulcer. Three other residents with pressure ulcers were added to the sample. All of the care plans had been updated to include pressure ulcer interventions. · During staff interviews on 08/02/12, licensed nursing staff reported their awareness of the wound treatment communication book. It was reported by the treatment nurse there were two books, one for each wing of the facility and staff were instructed to write concerns in the book for her to review daily. · The facility's wound care assessment protocol was updated on 08/01/12 and contained specific information as to treatment of each pressure ulcer by stage. · The pink copies of all telephone orders were	F 314		

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F 314	Continued From page 31 being given to the treatment nurse for daily review as of 08/02/12 and were discussed along with any concerns from the 24 hour report log in the daily scrub meetings per interview with the ADON on 08/02/12 at 10:35 AM. Verification of the credible allegation was evidenced by review of the inservice records sign in sheets and interviews with staff. Staff was observed completing the online computer pressure ulcer course on 08/03/12. Resident #118 was observed in bed with positioning cushions in place to float her heels. Resident #118's care card Kardex was updated on 08/03/12 to include specific interventions for pressure ulcer protection and prevention. Skin audit checks were reviewed on 08/03/12 and included discrepancies discussed with staff by the DON. The wound care specialist note was reviewed for Resident #118. Resident #118's care plan was reviewed and had been revised on 08/03/12. Three additional residents were reviewed for pressure ulcers and no concerns were identified.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	**F-323 (483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES** **A. <u>Corrective action taken for the affected resident.</u>** 1. For resident #7, on 7/25/2012 he was re-evaluated for smoking safety. Further, he was met with and informed of the facilities revised/updated resident safe smoking protocol.	8/3/12

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F 323	Continued From page 32 by: Based on observation, staff interviews and record review the facility failed to supervise a smoking resident who had been deemed an unsafe smoker due to past injury from smoking for 1 of 1 sampled residents (Resident #7). Findings include: Immediate jeopardy was identified on 08/01/12 at 10:40 AM. The immediate jeopardy began on 02/06/12 when resident #7 experienced new burns to his fingers, presumed to be the result of smoking, and was reassessed as a smoker now requiring supervision. The immediate jeopardy was removed on 08/03/12 at 10:02 AM when the facility demonstrated it had implemented its credible allegation of compliance. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy (D) so that audits could continue on the lock box where resident smoking materials were stored, on the supervisory status of residents on the smoking porch, and on the rooms of smoking residents. Findings include: Resident #7 was admitted to the facility on 9/11/08 with cumulative diagnoses of quadriplegia, lack of coordination and contracture of the hand joints. Resident #7 was cognitively aware. Resident #7's quarterly Minimum Data Set (MDS) dated 5/18/12 indicated that Resident #7 was totally dependent on staff. Resident #7 had functional impairments on both sides of the body in the upper and lower extremities. Resident #7 rejected care on 1-3 days during the MDS assessment period.	F 323	2. Social Worker and Administrator personally reviewed revised protocol with Resident #7 on 7/25/12. Since he remains classified as at risk for independent smoking, he was informed that he continues to be classified as a supervised smoker. 3. Resident #7 signed the "Resident Smoking Acknowledgement" form on 7/25/2012. 4. Cigarettes and ignition source of resident #7 secured and placed in locked safe box at Nursing station B and revised smoking safety protocol implemented. **B. <u>Corrective action taken for those residents having the potential to be affected by the deficient practice.</u>** 1. On 7/25/2012 a 100% audit of in-house residents was conducted to validate current smoker census. A total of 4 current residents (including resident #7) were validated as smokers. 2. The 3 residents, other than resident # 7, were re-evaluated for smoking safety. Two of the three residents were added to the facility list of at risk for independent smoking requiring supervision. The 4th and last was determined to be an independent safe smoker.	

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F 323	Continued From page 33 A review of the undated Kardex for Resident #7 under smoking showed spaces where independent and dependent could be checked. Neither area was checked. There was a check mark in front of smoking apron. Next to other, cigarette extender and smoking drape were handwritten in. A hand written note designating Resident #7 as a supervised smoker had a line through it. A review of the Unusual Occurrence Incident Report dated 2/6/12 showed that Resident #7 was smoking while sitting in a geri-chair on the smoking porch. There were 2 unpopped blisters on his left hand between the first and second fingers noted when he raised his hand to puff the cigarette. The actions taken to prevent reoccurrence of the injury included educating Resident #7 on smoking safety, the need to wear a smoking apron, and making Resident #7 a supervised smoker. A review of the Safe Smoking Assessment dated 2/6/12 showed that Resident #7 was an unsafe smoker and needed constant supervision while smoking. A review of the Nurse's Notes dated 2/6/12 at 3:00 PM indicated that Resident #7 had 2 2 centimeter unpopped blisters to the left hand between the first and second fingers. Resident #7 was made an unsafe smoker at that time. A review of the Skin Tears/Bruise Investigation Form dated 2/7/12 showed that Resident #7 was noted by a nurse to have blisters between the fingers which appeared to be from smoking.	F 323	3. These 3 remaining smokers were met with on 7/25/2012 by the Social Worker and the Administrator in a group setting. The revised/updated resident safe smoking protocol was presented to them and reason for implemented change. All three of the resident signed the Resident Smoking Acknowledgement form. 4. The care plans of the residents were updated 7/25/2012. 5. Cigarettes and ignition source of the three residents were secured and placed in locked safe box at Nursing station B and revised smoking safety protocol implemented. **C. <u>Measures Implemented and/or Systemic Changes made to ensure that deficient practices will not reoccur.</u>** 1. On 7/25/2012 a revised/updated practice for resident smokers was implemented. 2. From 7/25/2012 on, at risk resident smoker's cigarettes and ignition sources will not be allowed to be held in the custody of the resident. All such items shall be kept in a locked safe box at Nursing Station B per above listed revised smoking protocol.	

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F 323	Continued From page 34 A review of the Care Plan updated 5/21/12 showed Resident #7 was at risk for injury related to smoking and that he was non-compliant at times. Interventions included allowing for supervised smoking, wearing a smoking apron and using an extender on his cigarette. Resident #7 was also shown to have a problem of limited physical mobility related to quadriplegia and multiple contractures. Interventions included monitoring, documenting and reporting to the physician any signs or symptoms of immobility or worsening contractures. In an observation on 7/24/12 at 3:16 PM, Resident #7 was taken out to the smoker's patio by a staff member. The staff member came back into the building and told Resident #7's nurse that she had taken Resident #7 outside. In an observation on 7/24/12 at 3:17 PM, Resident #7 was sitting alone on the patio in a reclined geri-chair with a lit cigarette in his left hand. Resident #7's left hand jerked while he was holding the lit cigarette. There were no staff members outside providing supervision while he smoked. In an observation on 7/24/12 at 3:18 PM a staff member was observed on the patio with Resident #7 standing next to him smoking a cigarette. In an interview on 7/24/12 at 3:35 PM the Director of Nursing (DON) indicated that Resident #7 should be supervised at all times while he was smoking. She stated that Resident #7 refused to wear a smoker's apron and also refused to use an extender for his cigarette.	F 323	3. New residents will continue to be evaluated for smoking safety and resident and RP informed of protocols regarding safety and storage of smoking materials at Nursing Station B. Resident smoking safety assessments shall continue to be performed upon initial admission, annually and on an as needed basis due to a change of condition. 4. Resident smoking status shall be kept on the resident Kardex and updated by nursing management whenever a resident's smoking status changes. Status shall also be kept in the locked storage box on the inventory sheet. 5. Should an at risk resident smoker refuse to use necessary safety protective equipment, same shall be documented, care planned, information shared with responsible party and the resident will only smoke with one-on-one supervision. 6. For each resident smoker, an individualized smoker inventory tracking and safety requirement sheet was formulated and placed in the resident smoking lock box. Each time a resident requests a cigarette the staff will assure for arranging for resident safety while smoking while at the same time keep track of resident smoking item inventory.	

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F 323	Continued From page 35 In an interview on 7/24/12 at 4:39 PM Physical Therapist #1 indicated that she had lit Resident #7's cigarette and then had come back into the building. She stated that there were no other staff members outside supervising Resident #7. She indicated that Resident #7 was not a supervised smoker as she had seen Resident #7 outside smoking unsupervised a few times. In an interview on 7/25/12 at 10:10 AM Nurse #6 indicated that smoking assessments were done on admission and with any changes such as an injury. In an interview on 7/25/12 at 3:43 PM Resident #7 stated that someone was usually outside with him when he smoked because he was unable to light the cigarette. When asked about being left alone the day before he stated "So what?" Resident #7 refused to answer any more questions. In an interview on 7/25/12 at 5:10 PM Nursing Assistant #1 indicated that there were not always staff members outside supervising Resident #7 while he smoked. In an interview on 7/26/12 at 9:30 AM the Assistant DON (ADON) stated that she expected staff to stay with any resident who was a supervised smoker while they smoked. The supervised smoker should never be left alone with a lit cigarette because the resident could accidently set themselves on fire. She indicated that any staff member including dietary and rehabilitation could supervise a resident who was smoking.	F 323	7. Between 7/25 and 7/26, 2012 staff of all departments were in-serviced on the revised resident smoking protocol. Any staff member on vacation, leave or part-time/PRN staff during this period not in-serviced will not be allowed to begin work until in-serviced. 8. Responsible party for each resident has been informed of change in smoking protocol. **D. <u>How the facility plans to monitor its performance to assure ongoing compliance is sustained.</u>** 1. Management will check the smoking lock box daily to assure that for those smokers at risk there are initials of the attendant who supervised the resident smoking. 2. Effective 8/1/2012, Members of the management team will randomly check the resident smoking porch two times a shift to observe resident smokers and assure for compliance with smoking protocol. This will continue for 30 days until supervised designated smoking protocol is implemented 9/1/2012.	

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F 323	Continued From page 36 In an interview on 7/26/12 at 11:05 AM Restorative Aide #1 stated that sometimes Resident #7 was left outside to smoke unsupervised. In an interview on 7/26/12 at 11:48 AM Physical Therapist #1 indicated she should not have left Resident #7 alone after she lit his cigarette. She stated that she should have stayed with Resident #7 until the cigarette was put out. In an interview on 7/26/12 at 2:40 PM the DON stated that it was her expectation that staff stay with a supervised smoker until the resident's cigarette was extinguished. In a follow-up interview on 8/1/12 at 2:10 PM Restorative Aide #1 indicated the last time she had seen Resident #7 alone on the smoker's patio smoking was approximately 1 month ago. She stated that Resident #7 got up at about 2:00 PM everyday and went out to smoke once on her shift. She stated that since February 2012 she had seen him smoking unsupervised approximately 6-7 times. In a follow-up interview on 8/1/12 at 2:37 PM Physical Therapist #1 stated the last time she had seen Resident #7 smoking outside unsupervised was approximately 2-3 weeks ago. She indicated she had seen him smoking outside unsupervised approximately 2-3 times since February 2012. Physical Therapist #1 stated Resident #7 was supervised by a staff member while smoking 90% of the time. She indicated that the ADON had communicated to therapy regarding other residents in need of supervision while smoking.	F 323	3. Following 30-day notice to smokers, which was given 8/1/2012, designated resident smoking times for at-risk smokers will be implemented with staff assigned to distribute cigarettes and monitor resident smokers. 4. Beginning 8/1/2012 for a period of 3 months, randomly on a weekly basis, management team member spot checks of at risk smoking resident rooms will be made to assure for compliance with smoking materials storage protocol in the locked storage box. 5. Monitoring logs from above checks will be presented at the monthly safety committee meeting for the next three months. 6. Results of Safety Committee findings and recommendations will be presented to the QA Committee for review and recommendations for a period of three month. **E. <u>Date Corrective Action Completed:</u>** Corrective action was achieved on 8/3/2012.	

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F 323	Continued From page 37	F 323		

She stated her primary place to go for information regarding the residents would be their nurse. If the nurse was unavailable she would go to the ADON or the DON.

In an interview on 08/01/12 at 4:25 PM Nurse #10, who was the nurse the therapist told on 07/24/12 that she had left Resident #7 on the smoker's patio, stated she had cared for Resident #7 since mid-June 2012. The nurse reported this resident was supposed to utilize an apron and cigarette holder when smoking, but was non-complaint at times with their use. She commented until 07/25/12 she thought Resident #7 was an independent smoker, not requiring supervision. According to Nurse #10, staff had to take the resident outside and light his cigarettes, but he actually smoked unsupervised twice on second shift a lot. She explained it was not uncommon for the staff member who lit Resident #7's cigarettes to let someone know at the nurse's station the resident was outside on the smoker's patio because within thirty minutes or so the resident would send word that he was ready to come back inside the building. The nurse commented if NAs were not sure about a resident's smoking status they could refer to the resident's Kardex which documented this information.

In a follow-up interview on 08/01/12 at 4:36 PM NA#1 stated the only piece of protective clothing/equipment she had seen Resident #7 use when smoking was an apron. She reported she referred to the resident Kardex system if she was unsure of a resident's smoking status. According to NA #1, the last time she actually observed Resident #7 out on the smoker's patio

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F 323	Continued From page 38 was a couple of weeks ago. At that time, she commented, there were other residents out on the patio with Resident #7, but there were no staff members present. The NA explained Resident #7 had to be assisted to the patio where staff lit his cigarettes, but the resident smoked without staff supervision fairly frequently, about twice daily on second shift. The administrator was notified of the immediate jeopardy on 08/01/12 at 10:40 AM. The facility provided a credible allegation of compliance on 08/02/12 at 10:32 AM. The following interventions were put in place. · 07/25/12 Resident #7 was re-evaluated for smoking, was informed of the revised/updated safe smoking protocol, signed the Smoking Acknowledgement form, and had his smoking supplies placed in a lock box. · On 07/25/12 a 100% audit of in-house residents was conducted, and it was verified that a total of four current residents (including Resident #7) were smokers. All smoking residents were re-evaluated for smoking safety. Three of the residents were assessed as requiring supervision, and one was assessed as being an independent smoker. All smoking residents were informed of the revised/updated safe smoking protocol, their care plans and Kardexes were updated, and cigarettes and ignition sources for all smoking residents were secured in the lock box. On 07/25/12 it was determined that any smoking residents who refused to use the required protective equipment would only be able to smoke with one-on-one supervision.	F 323		

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F 323	Continued From page 39 · On 07/25/12 and 07/26/12 all facility staff was in-serviced on the revised resident smoking protocol. Staff on vacation, weekend staff, or as needed (PRN) staff were to be in-serviced prior to beginning work. · On 08/01/12 audits of the smoking lock box, the smoking patio, and the rooms of smoking residents began. These audits were implemented to make sure the staff and smoking residents were following policy regarding smoking supervision and the storing of resident smoking supplies. · Verification of the credible allegation was evidenced by review of in-service agendas and sign-in sheets, observance of employees being in-serviced on 08/01/12 through 08/03/12 who were not in attendance during previous in-services, and interviews with staff in which they verified attendance and summarized what they learned in the smoking in-services. Smoking residents were observed on the smoking patio, the lock box was observed, and the rooms of smoking residents were observed to make sure smoking supplies were not present. The revised/updated safe smoking policy was reviewed, care plans and Kardexes of smoking residents were reviewed to make sure the most current smoking status was documented, and facility audit sheets were reviewed. The immediate jeopardy at F323 was lifted on 08/03/12 at 10:02 AM.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328	F-328 (483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS A. <u>Corrective action taken for the affected resident.</u> 1. For Resident #74 an appointment with an external podiatrist has been scheduled for foot care evaluation and treatment.	8/16/12

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F 328	Continued From page 40 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to schedule 1 of 1 sampled residents (Resident #74) observed with long, jagged, mycotic toenails for contracted podiatry services. Findings include: Resident #74 was admitted to the facility on 05/18/12. The resident's documented diagnoses included Alzheimer's dementia, Parkinson's disease, atherosclerotic coronary artery disease, and cellulitis. The resident's 05/25/12 Admission Minimum Data Set (MDS) documented he was moderately impaired in his cognition, was totally dependent on a staff member for personal hygiene, and did not reject care. No care plan was generated from this assessment for the resident's dependence on the staff for his activities of daily living (ADLs). Weekly Skin Assessment Records documented Resident #74's toenails were last "trimmed" by staff on 06/09/12.	F 328	**B. <u>Corrective action taken for those residents having the potential to be affected by the deficient practice.</u>** 1. A 100% audit of all residents not currently scheduled for the 8/7/2012 in-house podiatrist foot clinic was conducted to determine status of any additional residents in need of foot nail(s) care, cutting or treatment. Four additional residents were identified. These residents could not get on the foot clinic list for treatment on 8/7/2012 so appointments were scheduled for them at community podiatrists office. **C. <u>Measures Implemented and/or Systemic Changes made to ensure that deficient practices will not reoccur.</u>** 1. Licensed and certified nursing department staff was in-serviced on the facility protocol for hand and foot nail care. 2. Daily, when resident showers are given, total body audits completed or bed-baths given, staff is to observe the residents for any needed toenail care. If podiatrist care is needed, the residents nurse is to be notified of resident foot care need. The nurse will document need on the 24-hour nurse supervisor report. Report is	

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F 328	Continued From page 41 Weekly Skin Assessment Records documented on 07/07/12 Resident #74's toenails were "thick, need cutting." There was no further documentation about the resident's toenails on these weekly records. At 3:17 PM on 07/24/12 Resident #74 was observed having long, jagged, mycotic toenails. At 10:26 AM on 07/25/12 Resident #74 was observed having long, jagged, mycotic toenails. At 8:12 AM on 07/26/12 surveyors observed pressure sore treatments provided to Resident #74's sacrum and heel. The resident's toenails were long, jagged, and mycotic. At 2:26 PM on 07/26/12 nursing assistant (NA) #6 stated she was assigned to care for Resident #74. She reported sometimes a family member of the resident provided some of his personal care. The NA commented she gave the resident a bed bath the morning of 07/26/12. Upon observing the resident's feet the NA stated the resident's toe nails needed to be cut and filed. The nails on the resident's big toes extended approximately 1/4 of an inch beyond the end of those toes, and the nails on the resident's other toes extended 1/8 to 1/4 of an inch beyond the end of the toes. The NA reported she would not attempt to cut Resident #74's toenails herself because they were too tough. However, she commented she could tell the nurse who would make sure the podiatrist cut the resident's toenails. According to NA #6, she did not tell the hall nurse that the resident had long and jagged toenails on 07/26/12 after giving the resident his bed bath.	F 328	reviewed each morning and when podiatrist care needed, nursing will secure a physicians order and schedule either an internal or external podiatrist examination. **D. <u>How the facility plans to monitor its performance to assure ongoing compliance is sustained.</u>** 1. The facility will continue its current in-place system of daily resident total body skin audits, resident scheduled showers and daily bed baths. 2. Effective 8/17/2012 on a daily basis, each nurse supervisor on the day and evening shifts, will conduct a separate random audit of one completed total body audit of the day, one shower skin audit of the day and one bed bath review audit of the day to confirm needed toenail care/condition report accuracy. This will occur daily for a period of one month after which practice will continue 5 times a week for a period of two months. 3. The nursing supervisor audits described in #2 above will be reviewed by the DON or ADON on a daily basis for the duration of the monitoring period. This will continue to be a part of the daily clinical scrub board review.	

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F 328	Continued From page 42 At 2:33 PM on 07/26/12 the assistant director of nursing (ADON) observed Resident #74's feet, and reported his toenails needed to be cut. She stated normally nurses or NAs could cut toenails, but Resident #74's toenails needed to be cut by the podiatrist because his nails were mycotic. The ADON commented she thought the podiatrist visited the facility every two to three months, and the facility's social worker (SW) was in charge of keeping the list of residents who were to see the podiatrist. At 2:36 PM on 07/26/12 the facility's SW stated she was responsible for maintaining the podiatry list. She reported contracted podiatry services visited the facility next on 08/07/12. She explained the podiatrist assessed residents in the facility quarterly. According to the SW, podiatry services reviewed resident charts one to two months prior to a visit to determine any new residents who might benefit from services, and generated a list of residents seen in the past who were due follow-up appointments. The SW stated nurses and NAs gave her verbal notice of residents who should be added to the podiatry list, and residents requiring podiatry services were also sometimes discussed in the morning meetings. She reported a list of residents to be seen on 08/07/12 had already been generated, but Resident #74 was not on that list, nor had he been added to that list. At 2:48 PM on 07/26/12 NA #2 stated resident toenails were cut as needed, but there was no set intervals at which toenail care was provided. She reported resident fingernails and toenails should be observed daily as care was provided,	F 328	4. For the next three month period, the results of the above audits shall be presented at the monthly Quality Assurance Committee meeting for compliance monitoring and any audit modification directives. **E. Date Corrective Action Completed:** Corrective action was achieved on 8/16/2012.	

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F 328	Continued From page 43 and when they were long, dirty, or jagged nail care should be rendered. According to NA #2, nurses or NAs could cut toenails, unless the resident was diabetic or the nails were mycotic, in which case the resident was added to the list to be seen by the podiatrist who visited the facility. She commented if NAs observed toenails which needed care, but they were unable to provide that care, the NAs were to notify the appropriate hall nurses. At 2:54 PM on 07/26/12 NA #6 stated Resident #74 was dependent on the staff for personal hygiene, and did not resist care. At 2:58 PM on 07/26/12 Nurse #2 stated Resident #74 was dependent on the staff for personal hygiene, and did not resist care. She reported as long as residents were not diabetic and their toenails were not mycotic, both nurses or NAs could provide nail care. This nurse commented resident toenail status was documented on the Weekly Skin Assessment Reports. She explained the nurse who completed the skin assessment and determined toenail care should be rendered either provided that care themselves or let the SW know to add the resident to the podiatry list. At 3:35 PM on 07/26/12 a MDS Nurse (Nurse #8) stated when residents were totally dependent on staff for all ADLs this problem was not usually identified in the care plan. Instead, she commented when residents required a variety in the degree of assistance the required for ADLs, this was care planned so staff would know which ADLs required extensive assistance, limited assistance, etc.	F 328		

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F 328	Continued From page 44 At 3:38 PM on 07/26/12 Nurse #9 stated Resident #74 was totally dependent on the staff for personal hygiene, and did not resist care. She reported the podiatry service cut all resident toenails. At 4:13 PM on 07/26/12 NA #8 stated Resident #74 was totally dependent on the staff for personal hygiene, and did not resist care. She reported first or second shift staff could provide nail care. She commented nurses cut the toenails of diabetic residents, and the foot doctor had to cut mycotic toenails. According to NA #8, if she observed long, jagged, dirty, or mycotic toenails when providing care, she either cut them herself, or notified the nurse who cut them, or notified the SW to place the resident(s) on the podiatry list. At 4:24 PM on 07/26/12 the director of nursing (DON) stated nail care was not provided at set intervals, but it was her expectation that the NAs looked at nails during daily baths or showers, and nurses documented on toenails on the Weekly Skin Assessment Records. She reported nurses had to cut the toenails of diabetic residents, and they could file mycotic toenails. However, she explained the podiatrist was responsible for cutting mycotic toenails. The DON commented the contracted podiatrist visited the facility every three months, and residents who required toenail care could also be referred to outside podiatrists if needed. According to the DON, after Nurse #2 documented Resident #74's toenails needed to be cut on the 07/07/12 Weekly Skin Assessment Record, the nurse should have cut them herself or immediately notified the SW to place the	F 328		

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F 328	Continued From page 45 resident on the list of residents to be seen when contracted podiatry services visited the facility next.	F 328		
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 observation and staff interview the facility failed to keep a cold salad made with mayonnaise at or below 41 degrees Fahrenheit during the operation of the trayline/ to keep a hot food item at 135 degrees or higher during the operation of the trayline, failed to dry kitchenware before stacking it in storage, and failed to discard food items past their use-by or best-by dates/ to label and date opened food items in storage. Findings include: 1. At 12:15 PM on 07/23/12 there was chicken salad in a full size, shallow tray pan on the steam table above another tray pan filled with ice which was mostly melted. A calibrated thermometer used to check the temperature of the chicken salad registered 56.1 degrees Fahrenheit. A dietary employee removed a half tray pan of chicken salad from the reach-in refrigerator to	F 371	**F-371 (483.35(i) FOOD PROCURE, STORE PREPARE/SERVE - SANITARY** **A. <u>Corrective action taken for the affected resident.</u>** 1. Identified prepared food items at inappropriate serving temperatures, food items with expired use by – best by dates and opened food items without dates and labels were immediately removed and discarded. Kitchenware with moisture droplets was secured and reprocessed per sanitation protocol. 2. The dietary staff members involved were immediately in-serviced by the Dietary Manager (DM) on a) proper protocols and processes for hot and cold food preparation and serving line temperature maintenance; b) dating and labeling new and opened food items storage protocols; c) process of checking for and discarding food products with expired use by – best by dates; and d) dietary protocols for air drying and storage of food preparation and serving kitchenware.	8/21/12

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	345063	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7156 WILSON, NC 27893

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F 371	Continued From page 46 replace the salad in the full tray pan. However, a calibrated thermometer used to check the temperature of this new salad only registered 71.8 degrees. Then a large metal bowl of chicken salad was removed from the same reach-in refrigerator to place on the trayline. However, a calibrated thermometer used to check the temperature of this new salad only registered 71.3 degrees Fahrenheit. At this time the cook stated she finished assembling the chicken salad at 11:15 AM on 07/23/12. She reported she used chicken cooked the morning of 07/23/12, and added relish and mayonnaise. The cook commented she stored the chicken salad in the reach-in refrigerator until the trayline started up at 11:30 AM on 07/23/12. The dietary manager (DM) stated she preferred for cold salads containing protein to be made up the day before they were scheduled to be served. According to the DM, there were still five more carts to go out to residents for the 07/23/12 lunch meal. At 11:42 AM on 07/25/12 the lunch trayline began operation. Greens, chicken noodle soup, hamburger patties, and cream soup were not on the steam table. Instead, they were on top of the stove/griddle behind the steam table. At 11:56 AM on 07/25/12 the cook placed cream soup from the pot on the stove into a soup/cereal bowl, and placed it on a resident's tray. At 12:07 PM on 07/25/12 the cook placed cream soup from the pot on the stove into a soup/cereal bowl, and placed it on a resident's tray. At 12:09 PM on 07/25/12 the cook removed some	F 371	**B. <u>Corrective action taken for those residents having the potential to be affected by the deficient practice.</u>** 1. The facility has determined that all residents who consume food by mouth have the potential to be affected. 2. Identified prepared food items at inappropriate serving temperatures, food items with expired use by – best by dates and opened food items without dates and labels were immediately removed and discarded. Kitchenware with moisture droplets was secured and reprocessed per air drying protocol. **C. <u>Measures Implemented and/or Systemic Changes made to ensure that deficient practices will not reoccur.</u>** 1. All dietary staff members were in-serviced and retrained, with observation, by the Certified Dietary Manager on a) proper protocols and processes for hot and cold food preparation and temperature maintenance; b) dating and labeling new and opened food items storage protocols; c) process of checking for and discarding food products with expired use by – best by dates; and d) dietary protocols for washing, sanitizing drying and storage of food preparation and serving kitchenware.	

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F 371	Continued From page 47 of the cream soup from the pot on the stove, and poured it over the chopped fish on the trayline. At 12:12 PM on 07/25/12 a calibrated thermometer used to check the temperature of the greens registered 158 degrees Fahrenheit, the temperature of the chicken noodle soup registered 153 degrees, the temperature of the hamburger patties registered 144 degrees, but the the temperature of the cream soup in the pot on the stove only registered 118 degrees Fahrenheit. There were more meal carts waiting to be filled with lunch trays. At 3:05 PM on 07/25/12 the DM stated cold salads were supposed to be prepared the day before they were served, should be stored in refrigeration, and brought out only 15 minutes before the trayline began operation. She reported cold salads should be placed in the end steam well over ice during the entire operation of the trayline. The DM commented the cook should have obtained a beginning temperature for cold salads before the trayline began operation, and the salads should not have been served unless a calibrated thermometer used to check their temperature registered between 33 and 40 degrees Fahrenheit. According to the DM, the cook recorded an initial temperature for the chicken salad, but she reported she was not sure it was an accurate temperature based on the thermometer reading at 12:15 PM on 07/23/12. The DM stated hot foods should be 140 degrees Fahrenheit or hotter during the entire operation of the trayline. She explained foods that would not fit into the wells of the steam table should be kept on the stove or in oven with heat on during the entire operation of trayline.	F 371	2. A Validation Checklist sheet was developed and completed for each dietary employee to determine if the employee was performing procedures for a) complying with hot and cold food preparation and maintenance on serving line; b) dating and labeling new and opened food items storage protocols; c) process of checking for and discarding food products with expired use by – best by dates; and d) dietary protocols for air drying and storage of food preparation and serving kitchenware in compliance with facility safety and sanitation protocols. Findings were reviewed with each employee. Corrective action was provided as needed. **D. <u>How the facility plans to monitor its performance to assure ongoing compliance is sustained.</u>** 1. The Dietary Manager (DM) or designee will personally complete random Validation Checklist follow-up audits on hot and cold food temperature compliance, food product dating and labeling requirement compliance, compliance with use by – best by expired date compliance and kitchenware air drying and storage protocols 3 times weekly to ensure staff is performing the procedures in accordance with facility policy.	

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F 371	Continued From page 48 At 3:17 PM on 07/25/12 the PM cook stated cold salads should be prepared the night before being served the next day. She explained the salads should be stored overnight in the refrigerator, and as the trayline began operation a few bowls or a few small tray pans should be removed from refrigeration and placed on the dessert rack until being put on resident trays. The cook reported new bowls/tray pans should continue to be removed from refrigeration as needed. She commented the cold salads should remain at 35 degrees Fahrenheit or below during the entire operation of the trayline. The DM stated hot foods should be kept at 160 - 180 degrees Fahrenheit during the entire operation of trayline. She explained if hot foods would not fit in the steam table, then they should be kept hot in the oven or on the stove. 2. During initial tour of the kitchen, beginning at 9:40 AM on 07/23/12, 3 of 6 tray pans stacked on top of one another in storage were wet inside. The dietary manager (DM) reported these tray pans were washed and sanitized in the three-compartment sink after the 07/23/12 breakfast meal. During an inspection of kitchenware, beginning at 9:52 AM on 07/25/12, 3 of 12 china side dishes stacked on top of one another in storage were wet inside. At 3:05 PM on 07/25/12 the DM stated the dietary employees who placed kitchenware in storage should make sure it was clean and dry before stacking it. The DM reported she checked periodically to make sure this was being done.	F 371	2. For the next three month period, the results of the Validation Checklist Audits will be presented at the monthly Quality Assurance Committee meeting for compliance monitoring and any audit modification directives. **E. <u>Date Corrective Action Completed:</u>** Corrective action was achieved on 8/21/2012.	

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F 371	Continued From page 49 At 3:17 PM on 07/25/12 the PM cook stated any kitchenware stacked in storage should be clean and dry. She reported she was not aware of any monitoring system to make sure this happened. 3. During initial tour of the kitchen, beginning at 9:40 AM on 07/23/12, there were food items in the dry storage room which had been opened, but were without labels and dates. Opened packages of whole wheat penne pasta, chocolate instant pudding, and sugar-free chocolate instant pudding were without labels and dates. In the reach-in freezer a bag of French fries and sleeve of pancakes were opened, but without labels and dates. In the kitchen a container of ground rosemary was opened, but without a label and date. In the walk-in refrigerator croissants in a plastic storage bag were without a label and date. Two five-pound containers of cottage cheese with a use-by/best-by date of 07/18/12 and two five-pound containers of pimento cheese with a use-by/best-by date of 06/23/12 were also found in the walk-in refrigerator. In the walk-in freezer diced ham and chicken cordon bleu in plastic storage bags were without labels and dates. During a revisit to the kitchen, beginning at 10:08 AM on 07/25/12, a five-pound container of pimento cheese with a use-by/best-by date of 06/11/12 was found in the reach-in refrigerator. Also a container of garlic powder found in the kitchen was opened, but without a label and date. At 3:05 PM on 07/25/12 the dietary manager (DM) stated leftovers, opened food items, and food items removed from their original packaging and placed in storage should be labeled and	F 371		

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F 371	Continued From page 50 dated. She reported the cooks, a stock person on stock day, one dietary employee on a daily basis, and she monitored storage areas to make sure items were labeled and dated and not past the use-by/best-by dates. The DM commented the facility did not use items which were past their use-by/best-by dates. At 3:17 PM on 07/25/12 the PM cook stated all dietary staff were responsible for making sure leftovers, opened food items, and food items removed from their original packaging were labeled and dated. She reported the facility did not use items which were past their use-by/best-by dates. However, she commented she was not aware of any dietary employee being responsible for monitoring storage areas to make sure food items were labeled and dated and not past their use-by/best-by dates.	F 371		