STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING _____ B. WING _____	08/09/2012

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COURTLAND TERRACE	2300 ABERDEEN BLVD GASTONIA, NC 28054

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F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herin. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kimberly K. Poovey | NHA | 8/30/12

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

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F 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156	Medicare Non-Coverage Notice mailed to Residents #111, #152, and #158, as these residents have been discharged. All residents eligible for Medicare coverage identified as having the potential to be affected. Inservice completed by Administrator to administrative staff regarding the approved Medicare Non-Coverage Notice. Audit conducted to identify all residents currently receiving Medicare covered services to ensure Medicare Non-Coverage Notice implementation. Medicare Non-Coverage Notice monitoring tool implemented to ensure compliance. Medicare Non-Coverage Notice monitoring tool to be completed by the Administrator three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Medicare Non-Coverage Notice monitoring tool incorporated into the facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12 9/3/12

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide the three (3) of three (3) sampled residents Medicare Non-Coverage notices (Residents #111, #152 and #158). The findings are: 1. Resident #111's Medicare covered services ended 02/28/12 and was discharged from the facility on 02/29/12. Resident #111 was not provided with an approved Notice of Medicare non-coverage letter that notified her Medicare services were ending, what the expected costs of care would be subsequently and her right to appeal. On 08/09/12 at 2:50 PM the Administrator was interviewed and reported that it was not the practice of the facility to notify residents with a	F 156		

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F 156	Continued From page 3 Medicare Non-coverage letter prior to their services ending. She stated that upon admission to the facility residents were notified in the admission packet of their right to appeal non-coverage. The Administrator provided no explanation why the facility did not provide residents with notification of their rights as Medicare recipients. 2. Resident #152's Medicare covered services ended on 03/19/12 and was discharged from the facility on 03/20/12. Resident #152 was not provided with an approved Notice of Medicare non-coverage letter that notified him Medicare services were ending, what the expected costs of care would be subsequently and her right to appeal. On 08/09/12 at 2:50 PM the Administrator was interviewed and reported that it was not the practice of the facility to notify residents with a Medicare Non-coverage letter prior to their services ending. She stated that upon admission to the facility residents were notified in the admission packet of their right to appeal non-coverage. The Administrator provided no explanation why the facility did not provide residents with notification of their rights as Medicare recipients. 3. Resident #158's Medicare covered services ended on 03/20/12 and was discharged from the facility on 03/21/12. Resident #158 was not provided with an approved Notice of Medicare non-coverage letter that notified her Medicare services were ending, what the expected costs of care would be subsequently and her right to appeal.	F 156		

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F 156	Continued From page 4 On 08/09/12 at 2:50 PM the Administrator was interviewed and reported that it was not the practice of the facility to notify residents with a Medicare Non-coverage letter prior to their services ending. She stated that upon admission to the facility residents were notified in the admission packet of their right to appeal non-coverage. The Administrator provided no explanation why the facility did not provide residents with notification of their rights as Medicare recipients.	F 156		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to initiate a comprehensive Significant Change Minimum Data Set for one (1) of one (1) residents reviewed for pressure ulcers and one (1) of two (2)	F 274		

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F 274	Continued From page 5 residents reviewed for initiation of Hospice services. (Resident #147). The findings are: Resident #147 was admitted to the facility 01/12/12 with diagnoses including metastatic prostate cancer. An admission Minimum Data Set (MDS) dated 01/19/12 indicated the resident had no pressure ulcer. A review of MDS documents revealed this admission MDS was the only comprehensive assessment recorded for Resident #147. A review of a weekly pressure ulcer record dated 02/23/12 and signed by the Director of Nursing (DON) was reviewed. The document described an unstageable sacral wound measuring 4.5 cm (centimeters) in length and 6 cm in width. Continued record review specified Resident #147 was readmitted to the facility on 02/23/12 with this sacral wound following an admission to an acute care facility. A review of Resident #147's medical record revealed a physician's order dated 05/04/12. The order requested a Hospice consult. Continued medical record review revealed Hospice admission papers dated 05/07/12 and signed by a family member. An interview with the DON on 08/08/12 at 5:10 PM revealed a Significant Change MDS assessment should have been initiated when the resident returned to the facility with an unstageable sacral wound. The DON added a Significant Change MDS assessment should have been completed when Resident #147 was	F 274	Comprehensive Assessment/Significant Change Minimum Data Set completed for Resident #147. All residents identified as having the potential to be affected. Audit conducted to identify any resident with a significant change in physical or mental condition requiring a comprehensive assessment/ significant change MDS. Inservice provided by Director of Nursing to MDS Assessment Nurses regarding the criteria for completing comprehensive assessment/significant change mds. Comprehensive assessment/significant change monitoring tool implemented to ensure compliance. Monitoring tool to be completed by the Director of Nursing three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Comprehensive assessment/significant change monitoring tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12 9/3/12

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F 274	Continued From page 6 admitted to Hospice. An interview with the MDS Coordinator (MDSC) on 08/09/12 at 10:30 AM confirmed the Admission MDS dated 01/19/12 was the only comprehensive assessment completed for Resident #147. She stated it was her understanding the resident returned from the hospital on Hospice care. She added she was aware a Significant Change MDS should be completed when a resident was admitted to Hospice. She was unable to explain why this was not done for Resident #147. The MDSC was unaware a Significant Change assessment should be completed following the development of an unstageable pressure ulcer.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

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F 279	Continued From page 7 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews the facility failed to develop and implement a care plan for one (1) of one (1) sampled hemodialysis resident. (Resident # 199) The findings are: A skilled nursing facility outpatient dialysis service agreement dated 04/17/08 read in part that parties would mutually develop written protocols governing responsibilities, policies and procedures and develop and implement a resident's plan of care relative to the provision of dialysis service. Resident #199 was admitted on 07/19/12 with diagnoses of end stage renal disease (ESRD), congestive heart failure, coronary artery disease and peripheral vascular disease. An admission Minimum Data Set (MDS) assessment dated 07/26/12 indicated no cognitive impairment. The MDS also indicated the resident required limited assistance with bed mobility and dressing and extensive assistance with transfer, personal hygiene and toileting. The MDS specified the resident received dialysis services. Review of Resident #199's medical record revealed a Care Area Assessment (CAA) for Activities of Daily Living dated 08/01/12 which indicated the Resident was diagnosed with ESRD and received hemodialysis three times a week. The CAA documented proceed to care plan.	F 279	Care Plan regarding outpatient hemodialysis service developed and implemented for Resident #199. All residents identified as having potential to be affected. Inservice completed by Director of Nursing to Interdisciplinary Care Plan Team in regards to developing a comprehensive plan of care identified in the comprehensive assessment. Review of the comprehensive plan of care for all current residents completed to ensure compliance. Comprehensive Care Plan monitoring tool implemented to ensure compliance. Monitoring tool to be completed by the Director of Nursing three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Comprehensive Care Plan monitoring tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12 9/3/12

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F 279	Continued From page 8 Continued review of the medical record revealed no plan of care was developed to address the needs of a resident receiving hemodialysis services. On 08/08/12 at 5:13 PM the Director of Nursing (DON) was interviewed. The DON stated she expected the MDS nurse to have assured a care plan was developed for a resident receiving dialysis services. On 08/09/12 at 8:33 AM the MDS Nurse was interviewed. The MDS Nurse stated he only initiated a care plan for areas that triggered a CAA. He stated dialysis was not an area that would have triggered a CAA but a plan of care should have been implemented, as the care plan would have directed the care provided to the resident.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to monitor a resident's dialysis access site for potential complications for one (1) of one (1) residents receiving hemodialysis. (Resident #199).	F 309		

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F 309	Continued From page 9 The findings are: Review of a facility nurses meeting dated 05/21/12 revealed that nurses were instructed to look for the following areas on a dialysis patient returning to the facility: vital signs to indicate low blood pressure, mental status changes, bleeding from site, feel for a bruit/ thrill over the fistula site, and note any psychological changes/ concerns. Resident #199 was admitted on 07/19/12 with diagnoses of end stage renal disease (ESRD), congestive heart failure, coronary artery disease and peripheral vascular disease. An admission Minimum Data Set (MDS) assessment dated 07/26/12 indicated no cognitive impairment. The MDS also indicated the resident required limited assistance with bed mobility and dressing and extensive assistance with transfer, personal hygiene, and toileting. The MDS specified the resident received dialysis services. Continued review of the medical record revealed no plan of care was developed to address the needs of a resident receiving hemodialysis services. Review of Resident #199's nursing notes dated 07/20/12 through 08/08/12 indicated no monitoring of the dialysis access site. The Nursing Supervisor was interviewed on 08//08/12 at 2:15 PM. She explained nurses were expected to use their own judgment to determine if blood pressures should be monitored after dialysis. The Nurse Supervisor stated nurses were expected to check dialysis fistula sites for redness, swelling or pain.	F 309	Dialysis access site for Resident #199 assessed and monitored for potential complications. All residents with dialysis access site identified as having the potential to be affected. Inservice completed by Staff Development Coordinator to licensed nursing staff in regards to monitoring dialysis patients for complications, specifically related to vital signs(respirations, pulse, blood pressure) and access site(bruit/thrill, redness, swelling, pain, drainage). Dialysis monitoring tool implemented to ensure compliance. Monitoring tool to include monitoring of vital signs and access site for the dialysis patient. Assistant Clinical Manager to complete Dialysis monitoring tool daily for two weeks; then three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Dialysis monitoring tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12

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F 309	Continued From page 10 An interview with Nurse Practitioner (NP) #1 on 08/08/12 at 3:49 PM revealed she expected the nursing staff to check vital signs, observe the dressing for bleeding and check the fistula for bruit and thrill for a resident returning from dialysis. On 08/08/12 at 4:19 PM an interview was conducted with Licensed Nurse (LN) #4. She revealed when Resident #199 returned from dialysis, she took a set of vital signs, observed him for any mental status changes but did not check the fistula site. An interview with the Director of Nursing (DON) on 08/08/12 at 5:13 PM revealed she expected the nurses to monitor residents upon return from dialysis for bleeding around dressing site, check the fistula for patency by listening for bruit and palpating for thrill and perform a general assessment to ensure no changes in condition. During an interview with LN #3 on 08/09/12 at 9:22 AM, she stated she was unaware of the need to assess the dialysis access site for bleeding/infection/ bruit or thrill. She further added that she did not check patency of the fistula site because she was unaware of how to perform this task. A telephone interview with the Clinical Manager at the Dialysis Center on 08/09/12 at 11:33 AM revealed Resident #199 had a left arteriovenous (AV) fistula. She explained the presence of a bruit and thrill signified that the AV fistula was patent and functional. She explained a nurse would listen for a bruit (swishing sound) and feel to check for a thrill (vibration). She also stated that	F 309		

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F 309	Continued From page 11 when a resident returned to the nursing center after dialysis the dressing should be removed and the bruit and thrill checked. She further explained that clots could form within the fistula and occlude the flow of blood, if not identified immediately the clots could cause damage to the fistula. She added that frequent checks of the bruit and thrill would ensure immediate identification of occlusion. Thus in the absence of the bruit and thrill a dialysis patient could be sent out for immediate treatment which could prevent the need for a new access placement or delay in dialysis treatment. A telephone interview with the Physician on 08/09/12 at 11:43 AM revealed monitoring the bruit and thrill ensured that the shut was patent. He stated that he would expect the nurses to check the bruit and thrill with vital signs and periodically. A follow-up interview with LN #4 on 08/09/12 at 11:43 AM revealed she did not routinely check the fistula site for bleeding or bruit and thrill.	F 309		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure it was free of medication error rate greater than 5% as evidenced by five (5) medication errors out of	F 332		

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F 332	Continued From page 12 fifty-three (53) opportunities, resulting in a medication error rate of 9.43%, for five (5) of twelve (12) residents observed during medication pass (Residents #197, #199, #154, #29 and #200). The findings are: 1. On 08/07/12 at 3:52 PM Registered Nurse (RN) #1 was observed administering medications to Resident #154. She administered Baclofen 10 milligrams (mg) by mouth and administered four (4) units of Humalog insulin via injection for a blood sugar level of 242. A review of the Resident's medical record revealed a physician order which read: "Fingerstick blood sugar check before each meal with Humalog sliding scale coverage: 70-140= 0 units, 141-190= 1 unit, 191-240= 2 units, 241-290= 3 units, 291-340= 4 units, 341-390= 5 units, >390= 6 units". A review of the Medication Administration Record (MAR) revealed this order had been correctly transcribed for the administration of 3 units of Humalog insulin for a blood sugar reading of 242. On 08/07/12 at 4:29 PM, RN #1 was interviewed. She acknowledged that she had given four (4) units of insulin instead of three (3) units for a blood sugar reading of 242 for Resident #154. She stated that she just made a mistake. On 08/08/12 at 2:15 PM, Nurse Practitioner (NP) #2 was interviewed. NP #2 stated that she would have expected the nurse to have rechecked the resident's blood sugar within an hour and contact the physician if she noted him to be	F 332	Physician and Resident/Responsible Party notified of medication error for Residents #197, #199, #154, #29, and #200. All residents identified as having the potential to be affected. Inservice completed by Staff Development Coordinator for licensed nursing staff in regards to medication errors and medication administration, specifically related to administration of insulin, injections, nasal sprays, inhalers, and omissions. Inservice includes procedure for proper medication administration of right resident, right drug, right dose, right route, and right time. Medication administration monitoring tool implemented to ensure compliance. Medication Administration monitoring tool includes medication administration observation, with a focus on insulin, injections, nasal sprays, inhalers, and omissions. Medication administration monitoring tool to be completed by the Assistant Clinical Manager daily for two weeks; then three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Medication administration monitoring tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12

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F 332	Continued From page 13	F 332		

hypoglycemic. She also stated that she would have wanted to be made aware that the wrong does of insulin was administered even if the resident did not present with signs or symptoms of hypoglycemia.

On 080/8/12 at 4:27 PM RN #1 was interviewed. She stated that she did not recheck Resident #154's blood sugar within the hour because she was familiar with the Resident and knew that she would be checking his blood sugar again within the next 4 hours to ensure it had not dropped too low.

An interview with the Director of Nursing (DON) on 08/08/12 at 4:55 PM revealed that she expected RN #1 to notify the physician immediately and would have expected her to recheck the Resident's blood sugar within 30 minutes after the wrong dose of insulin was administered.

2. On 8/7/12 at 4:04 PM, Registered Nurse (RN) #1 was observed administering medications to Resident #199. She administered 4 units of Novolog insulin via injection and the following medications by mouth: Pravachol 40 milligrams (mg) - one tablet; Phoslo 667 mg- one capsule and Deep Sea nasal spray - one spray in each nostril.

A review of the Resident's medial record revealed a physician's order which read: "Ocean Mist use 2 sprays in each nostril 4 times daily" . A review of the Medication Administration Record (MAR) revealed the order had been correctly transcribed for the administration of two (2) sprays to each nostril at 8:00 AM, 12:00 PM, 4:00 PM and 8:00

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F 332	Continued From page 14 PM. On 08/07/12 at 4:17 PM RN #1 was interviewed. She acknowledged that she failed to administer the nasal spray as ordered and that the Resident should have received two (2) sprays to each nostril instead of one. On 08/08/12 at 5:00 PM the Director of Nursing (DON) was interviewed. She stated facility nurses have been taught when giving medications to make sure they have the right resident, right drug, right dose, right route, and right time. She stated that she expected medication administration to be accurate and according to physician orders. 3. On 08/08/12 at 8:02 AM Licensed Nurse (LN) #3 was observed administering medications to Resident #19. She administered Cubicin 500 milligrams (mg)/100 milliliters (ml) via intravenous access and the following medications were administered by mouth: Vitamin and Mineral supplement - one tablet, Vitamin D 3 1000 units- two tablets, Hydrochlorothiazide 12.5 mg- one tablet, Colace 100 mg- one capsule, Aspirin 81 mg- one tablet, Diovan 160 mg - one tablet and Florastor 250 mg- one capsule. A review of the Resident's medical record revealed a physician order which read: "Toprol XL 50 mg take 1 tablet by mouth daily, do not crush" A review of the Medication Administration Record (MAR) revealed this order had been correctly transcribed for administration of one 50 mg tablet at 9:00 AM. On 08/08/12 at 8:22 AM LN #3 acknowledged	F 332		

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F 332	Continued From page 15 that she had failed to administer one tablet of Toprol XL to the Resident. She stated that she thought she had given the medication and would go back to the Resident's room and administer the medication immediately. On 08/08/12 at 5:00 PM the Director of Nursing (DON) was interviewed. She stated facility nurses have been taught when giving medications to make sure they have the right resident, right drug, right dose, right route, and right time. She stated that she expected medication administration to be accurate and according to physician orders. 4. Resident #29 was admitted to the facility with diagnoses including recurrent urinary tract infections. A review of the August 2012 Physician's Monthly orders revealed an order for Vitamin C 1000 milligrams (mg) one (1) tablet by mouth daily. A review of the August 2012 Medication Administration Record revealed a physician's order for Vitamin C 1000 mg one (1) tablet by mouth daily. An observation of medication administration initiated at 7:45 AM on 08/08/12 revealed Licensed Nurse (LN) #2 administered one (1) tablet of Vitamin C 500 mg to Resident #29. An interview with LN #2 on 08/08/12 at 12:39 PM confirmed she did administer one (1) tablet of Vitamin C to Resident #29. She stated when she read the instructions, she saw one (1) tablet. LN	F 332		

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F 332	Continued From page 16 #2 stated she did not connect the tablets provided were 500 mg each and would require two (2) to equal 1000 mg. An interview with the Nurse Practitioner on 08/08/12 at 12:50 PM revealed the intent of the Vitamin C order for Resident #29 was to administer 1000 mg per daily dose. An interview with the Director of Nursing (DON) on 08/08/12 at 4:54 PM revealed she expected LN read the entire physician's order and medication label before administering medication. 5. A review of the package insert dated January 2011 containing medical information regarding Advair was conducted. Common side effects listed included thrush (a yeast infection) in the mouth. Instructions contained in the insert specified to rinse the mouth with water after breathing in the medicine and spit the water out to help prevent formation of infection. Resident # 200 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease. A review of the August 2012 Physician's Monthly orders revealed an order for Advair Diskus one(1) dose inhaled twice a day. A review of the August 2012 Medication Administration Record (MAR) revealed a physician's order for Advair Diskus one (1) dose inhaled twice a day with no further instructions provided. An observation of medication administration at 8:33 AM on 08/08/12 revealed Licensed Nurse	F 332		

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F 332	Continued From page 17 (LN) #1 administered the Advair Diskus as ordered to Resident #200. No mouth rinse was provided to the resident after the inhalation of Advair. An interview with LN #1 on 08/08/12 at 8:39 AM revealed instructions to rinse after inhaling Advair were not on the MAR. She stated she knew some inhalers required a rinse after use and some did not. She was unable to recall which inhalers did require a rinse. An interview with Resident #200 on 08/08/12 at 8:42 AM revealed she had used several inhalers over the years including Advair. She stated if she did not rinse her mouth with water following use of Advair, she was at risk for developing an infection. Resident #200 stated she had experienced that infection in the past. She confirmed no water was offered to her to rinse her mouth after the use of the Advair inhaler. An interview with the Director of Nursing on 08/08/12 at 4:54 PM revealed she expected licensed nurses offer a water mouth rinse to residents following the use of Advair inhalers.	F 332		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced	F 363		

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F 363	Continued From page 18 by: Based on observation, staff interview and review of the menus, the facility failed to served scrambled eggs in portions according to the menu. Residents on a regular and mechanical soft diet were served one-fourth (1/4) cup of scrambled eggs instead of one-third (1/3) cup according to the menu. The findings are: A continuous observation of the breakfast tray line occurred on 08/08/12 from 07:35 AM - 08:13 AM. Dietary Staff #1 was observed plating the breakfast meal. Dietary Staff #1 was observed to plate scrambled eggs with a #16 serving utensil (1/4 cup) for residents on regular and mechanical soft diets. Review of the facility menu revealed residents on regular and mechanical soft diets were to receive a #12 serving (1/3 cup) of scrambled eggs. An interview with Dietary Staff #1 on 08/08/12 at 08:00 AM revealed that a 1/4 cup serving utensil was the serving size she usually provided to residents who received scrambled eggs. She stated that she checked the number stamped on the inside of the bowl of the utensil to be sure she was using the right size. Dietary Staff #1 denied referencing the menu to verify the appropriate serving size for each food item served. Dietary Staff #1 was observed to continue the breakfast tray line serving scrambled eggs with a 1/4 cup serving utensil. During an interview on 08/08/12 at 08:12 AM with the Certified Dietary Manager (CDM) and review of the menu, the CDM confirmed that the serving	F 363	Residents will be served appropriate food portions according to menu. All residents identified as having the potential to be affected. Inservice completed by Staff Development Coordinator for Dietary Staff regarding serving food portions according to menu. Food Portion monitoring tool implemented to ensure compliance. Food portion monitoring tool to be completed by the Assistant Clinical Manager daily for two weeks; then three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Food portion monitoring tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate Effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12

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F 363	Continued From page 19 size for scrambled eggs to the forty-eight (48) residents who received a regular diet and the fifteen (15) residents who received a mechanical soft diet was a 1/3 cup serving according to the menu. The CDM stated that she did not usually check the serving utensils used during the tray line, rather this was the responsibility of the cooks. The CDM was observed to inform Dietary Staff #1 to use a 1/3 cup serving utensil to serve scrambled eggs, but Dietary Staff #1 continued using a 1/4 cup serving utensil. During an interview with the consultant Registered Dietitian on 08/08/12 at 10:11 AM she stated that the facility should serve portions of food according to the menu.	F 363		
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the menus, the facility failed to prepare pureed rice and pureed meat to a smooth, homogenous, pudding-like consistency for three (3) of eleven (11) residents with a physician's diet order for pureed foods. (Residents #86, #23 and #39) The findings are: 1. Resident #86 was admitted to the facility February 2012. Diagnoses included Alzheimer's	F 365		

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F 365	Continued From page 20 dementia and organic psychotic mental disorder. Review of a Significant Change Minimum Data Set dated 06/07/12 assessed Resident #86 with short and long-term memory impairment, severely impaired daily decision-making skills, requiring a mechanically altered and therapeutic diet and a swallowing disorder evident by holding food in her mouth/cheeks. Review of the August 2012 cumulative physician's order sheet revealed Resident #86 received a pureed diet with nectar thickened liquids with strict use of compensatory safe swallow strategies and the avoidance of straws. An observation of the dinner tray line in progress occurred on 08/07/12 at 4:45 PM. The dinner menu for residents with a physician's order for a pureed diet included turkey, rice, carrots and chocolate cake. Dietary Staff #1 was observed to plate pureed foods for residents on pureed diets. The consistency of the pureed turkey was observed soupy and poured onto the plate; the turkey was not in a pudding or mashed potato-like consistency and did not hold a form on the plate. Additionally, the pureed rice was observed with a grainy/lumpy texture and was not smooth. Interview with Dietary Staff #1 on 08/07/12 at 4:50 PM revealed she prepared pureed rice by putting a portion of cooked rice and approximately one-fourth (1/4) cup of water in a high speed blender to puree the rice. She stated she also added an unspecified amount of additional water because as she blended the rice and water, the rice would thicken and required additional water. For the pureed turkey, Dietary Staff #1 stated she used a canned product and did not add anything	F 365	Pureed food prepared to a form designed to meet individual needs for Residents #86, #23, and #39. All residents identified as having the potential to be affected. Inservice completed by Staff Development Coordinator for Dietary Staff in regards to consistency of pureed food and preparing food in a from designed to meet individual needs. Pureed food monitoring tool implemented to ensure compliance. Pureed food monitoring tool to ensure pureed food is a smooth, homogenous, pudding-like consistency. Pureed food monitoring tool to be completed by the Assistant Clinical Manager daily for two weeks; then three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Pureed food monitoring tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12

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F 365	Continued From page 21 to thicken it. Dietary Staff #1 further stated she did not use a recipe or specific measurements when she prepared pureed foods, she just pureed foods until the foods were soft enough. During an interview with the Certified Dietary Manager (CDM) on 08/07/12 at 4:55 PM, she stated that she had not provided cooks any specific instruction on how to puree foods because cooks knew what to do. The CDM further stated that she monitored tray lines for problems, but had not identified a concern with the consistency of pureed foods. The CDM observed the pureed rice and pureed turkey and confirmed that the rice should be a smooth consistency and that the pureed turkey was too thin. A test tray of a pureed diet was requested on 08/07/12 at 5:10 PM with the Administrator present. The rice was tasted and observed to have a grainy/lumpy texture that required chewing, the pureed turkey poured from the spoon. The Administrator stated she could provide no explanation as to why the pureed turkey was so thin. An interview on 08/09/12 at 9:30 AM with the Speech Therapist (ST) and observation of the test tray from dinner on 08/07/12 revealed that the ST expected residents on a pureed diet to receive foods of a smooth, homogenous, pudding-like consistency. The ST stated that she monitored the consistency of pureed foods when she treated residents who required pureed foods. Currently she was not providing speech therapy to a resident who required pureed foods. She stated when she had a concern regarding the	F 365		

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F 365	Continued From page 22 consistency of pureed foods, she mentioned this concern to the CDM. The ST tasted the pureed turkey and stated that it was a little thin and runny and should be thicker. She tasted the rice and stated that it required oral manipulation and should be smoother. The ST also stated that she was aware of at least three (3) residents who would require a thicker pureed meat for safety and rice that was smooth because of their diagnoses and identified Resident #86 one (1) of the three (3) residents. On 08/08/12 at 10:11 AM, the consultant Registered Dietitian (RD) was interviewed and stated that she had an opportunity to observe the consistency of pureed foods at least monthly. The RD stated she was aware of a family member who voiced a concern in the past that pureed meat served to her mom was too thin and this concern was addressed with the CDM. The RD stated she was not aware of a current concern with the consistency of pureed foods, but confirmed that pureed foods should be smooth and of a pudding/mashed potato-like consistency. 2. Resident #23 was admitted to the facility in June 2004. Diagnoses included dementia, psychosis and possible recurrent aspiration pneumonia. A Quarterly Minimum Data Set dated 07/07/12 assessed Resident #23 as having impaired short and long-term memory, severely impaired daily decision-making skills and requiring a mechanically altered therapeutic diet. Review of the August 2012 cumulative physician's order sheet revealed Resident #23 received a pureed diet with honey thickened liquids with strict use of compensatory safe	F 365		

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F 365	Continued From page 23 swallow strategies. An observation of the dinner tray line in progress occurred on 08/07/12 at 4:45 PM. The dinner menu for residents with a physician's order for a pureed diet included turkey, rice, carrots and chocolate cake. Dietary Staff #1 was observed to plate pureed foods for residents on pureed diets. The consistency of the pureed turkey was observed soupy and poured onto the plate; the turkey was not in a pudding or mashed potato-like consistency and did not hold a form on the plate. Additionally, the pureed rice was observed with a grainy/lumpy texture and was not smooth. Interview with Dietary Staff #1 on 08/07/12 at 4:50 PM revealed she prepared pureed rice by putting a portion of cooked rice and approximately one-fourth (1/4) cup of water in a high speed blender to puree the rice. She stated she also added an unspecified amount of additional water because as she blended the rice and water, the rice would thicken and required additional water. For the pureed turkey, Dietary Staff #1 stated she used a canned product and did not add anything to thicken it. Dietary Staff #1 further stated she did not use a recipe or specific measurements when she prepared pureed foods, she just pureed foods until the foods were soft enough. During an interview with the Certified Dietary Manager (CDM) on 08/07/12 at 4:55 PM, she stated that she had not provided cooks any specific instruction on how to puree foods because cooks knew what to do. The CDM further stated that she monitored tray lines for problems, but had not identified a concern with the consistency of pureed foods. The CDM	F 365		

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F 365	Continued From page 24 observed the pureed rice and pureed turkey and confirmed that the rice should be a smooth consistency and that the pureed turkey was too thin. A test tray of a pureed diet was requested on 08/07/12 at 5:10 PM with the Administrator present. The rice was tasted and observed to have a grainy/lumpy texture that required chewing, the pureed turkey poured from the spoon. The Administrator stated she could provide no explanation as to why the pureed turkey was so thin. An interview on 08/09/12 at 9:30 AM with the Speech Therapist (ST) and observation of the test tray from dinner on 08/07/12 revealed that the ST expected residents on a pureed diet to receive foods of a smooth, homogenous, pudding-like consistency. The ST stated that she monitored the consistency of pureed foods when she treated residents who required pureed foods. Currently she was not providing speech therapy to a resident who required pureed foods. She stated when she had a concern regarding the consistency of pureed foods, she mentioned this concern to the CDM. The ST tasted the pureed turkey and stated that it was a little thin and runny and should be thicker. She tasted the rice and stated that it required oral manipulation and should be smoother. The ST also stated that she was aware of at least three (3) residents who would require a thicker pureed meat for safety and rice that was smooth because of their diagnoses and identified Resident #23 one(1) of the three (3) residents. On 08/08/12 at 10:11 AM, the consultant	F 365		

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	345350	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BLVD GASTONIA, NC 28054

(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 365	Continued From page 25 Registered Dietitian (RD) was interviewed and stated that she had an opportunity to observe the consistency of pureed foods at least monthly. The RD stated she was aware of a family member who voiced a concern in the past that pureed meat served to her mom was too thin and this concern was addressed with the CDM. The RD stated she was not aware of a current concern with the consistency of pureed foods, but confirmed that pureed foods should be smooth and of a pudding/mashed potato-like consistency. 3. Resident #39 was admitted to the facility in January 2008. Diagnoses included aspiration pneumonia. Review of a quarterly Minimum Data Set dated 06/01/12 assessed Resident #39 with impaired short and long-term memory, severely impaired daily decision-making and requiring a mechanically altered therapeutic diet. Review of the August 2012 cumulative physician's order sheet revealed Resident #39 received a pureed diet with honey thickened liquids with strict use of compensatory safe swallow strategies. An observation of the dinner tray line in progress occurred on 08/07/12 at 4:45 PM. The dinner menu for residents with a physician's order for a pureed diet included turkey, rice, carrots and chocolate cake. Dietary Staff #1 was observed to plate pureed foods for residents on pureed diets. The consistency of the pureed turkey was observed soupy and poured onto the plate; the turkey was not in a pudding or mashed potato-like consistency and did not hold a form on the plate. Additionally, the pureed rice was observed with a grainy/lumpy texture and was not smooth.	F 365		

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F 365	Continued From page 26 Interview with Dietary Staff #1 on 08/07/12 at 4:50 PM revealed she prepared pureed rice by putting a portion of cooked rice and approximately one-fourth (1/4) cup of water in a high speed blender to puree the rice. She stated she also added an unspecified amount of additional water because as she blended the rice and water, the rice would thicken and required additional water. For the pureed turkey, Dietary Staff #1 stated she used a canned product and did not add anything to thicken it. Dietary Staff #1 further stated she did not use a recipe or specific measurements when she prepared pureed foods, she just pureed foods until the foods were soft enough. During an interview with the Certified Dietary Manager (CDM) on 08/07/12 at 4:55 PM, she stated that she had not provided cooks any specific instruction on how to puree foods because cooks knew what to do. The CDM further stated that she monitored tray lines for problems, but had not identified a concern with the consistency of pureed foods. The CDM observed the pureed rice and pureed turkey and confirmed that the rice should be a smooth consistency and that the pureed turkey was too thin. A test tray of a pureed diet was requested on 08/07/12 at 5:10 PM with the Administrator present. The rice was tasted and observed to have a grainy/lumpy texture that required chewing, the pureed turkey poured from the spoon. The Administrator stated she could provide no explanation as to why the pureed turkey was so thin.	F 365		

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F 365	Continued From page 27 An interview on 08/09/12 at 9:30 AM with the Speech Therapist (ST) and observation of the test tray from dinner on 08/07/12 revealed that the ST expected residents on a pureed diet to receive foods of a smooth, homogenous, pudding-like consistency. The ST stated that she monitored the consistency of pureed foods when she treated residents who required pureed foods. Currently she was not providing speech therapy to a resident who required pureed foods. She stated when she had a concern regarding the consistency of pureed foods, she mentioned this concern to the CDM. The ST tasted the pureed turkey and stated that it was a little thin and runny and should be thicker. She tasted the rice and stated that it required oral manipulation and should be smoother. The ST also stated that she was aware of at least three (3) residents who would require a thicker pureed meat for safety and rice that was smooth because of their diagnoses and identified Resident #39 one (1) of the three (3) residents. On 08/08/12 at 10:11 AM, the consultant Registered Dietitian (RD) was interviewed and stated that she had an opportunity to observe the consistency of pureed foods at least monthly. The RD stated she was aware of a family member who voiced a concern in the past that pureed meat served to her mom was too thin and this concern was addressed with the CDM. The RD stated she was not aware of a current concern with the consistency of pureed foods, but confirmed that pureed foods should be smooth and of a pudding/mashed potato-like consistency.	F 365		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 28 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to 1) remove expired cheese from refrigeration, 2) label and date diced meat stored in refrigeration, 3) defrost two (2) of two (2) ice cream freezers, and 4) maintain a grill under sanitary conditions. Cheese was stored in the refrigeration beyond a manufacturer's expiration date. Diced chicken and diced turkey was removed from the freezer and placed in the refrigerator to thaw without a date of storage. Two ice cream freezers were observed with a thick build-up of ice. The grill was observed with a thick build-up of grease and black food debris. Findings include: 1. An observation of the hospital kitchen occurred on 08/06/2012. The following concerns with food storage were identified. a. On 8/6/12 at 11:00 AM, the salad cooler was observed with four boxes that contained a ten pound bag of diced chicken per box and one box with a ten pound bag of diced turkey. The chicken and turkey were thawed. There was no date of	F 371	Expired cheese removed from refrigerator and discarded, diced meat labeled and dated, ice cream freezers defrosted, and grill cleaned. All residents identified as having the potential to be affected. Audit conducted for all refrigerators and freezers. Audit conducted to identify expired and unlabeled food items. Audit conducted of kitchen equipment to ensure cleanliness and sanitary conditions. Inservice completed by Staff Development Coordinator for Dietary Staff related to cleaning equipment and storing, preparing, distributing, and serving food under sanitary conditions. Cleanliness of Equipment and Food Storage/Preparation/Distribution monitoring tool implemented to ensure compliance. Cleanliness of Equipment and Food Storage/ Preparation/Distribution monitoring tool to be completed by Food Service Manager daily for two weeks; then three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Food storage/ preparation/distribution monitoring tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance.	9/3/12 9/3/12 9/3/12 9/3/12

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F 371	Continued From page 29 storage on the boxes of chicken or turkey. The Assistant Food Service Director was interviewed during the observation. He stated that he thought the chicken and turkey were both delivered to the facility on Friday 08/03/12 placed in the freezer and then moved from the freezer to the refrigerator to thaw. He further stated that to be certain, staff should have recorded the date the items were placed in the refrigerator to thaw. b. On 08/06/12 at 11:09 AM, eight (8) plastic bags, five (5) pounds each, of Monterey Jack cheese with jalapenos (four bags) and Blue cheese (four bags) were observed stored on the bottom shelf of the produce cooler. A manufacturer's date stamp of 06/28/12 was observed on each bag of Monterey Jack cheese and the cheese was observed with black and red discoloration on the surface of the cheese. The Blue cheese was observed with a cream colored liquid substance in the bottom of each bag. The eight (8) bags of cheese did not record a date of storage. The Assistant Food Service Director was observed to immediately discard the bags of cheese and stated that since the bags of cheese had been removed from the original boxes it was unclear how long the cheese was stored in the refrigerator. He identified the date stamp of 06/28/12 on the bags of Monterrey Jack cheese as the date of expiration. 2. An observation of the facility kitchen occurred on 08/07/12. The following concerns were identified with cold storage units and cooking equipment.	F 371		

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F 371	Continued From page 30 a. Two ice cream freezers were observed on 8/07/2012 at 4:30 PM. Both freezers were observed with approximately one half (1/2) inch to one (1) inch thick ice build-up on all four (4) walls inside the freezers. The ice cream freezers were observed used to store ice cream, frozen meats and nutritional supplements. An interview with the Certified Dietary Manager (CDM) on 08/07/12 at 4:30 PM revealed that she expected the freezers to be defrosted every two (2) weeks. The CDM stated that she created a cleaning schedule as needed and informed her staff when equipment needed to be cleaned. The CDM did not know when the freezers were last defrosted and cleaned and stated that both freezers needed to be defrosted and cleaned. b. An observation occurred on 08/07/2012 at 4:35 PM of the grill. The grill was observed with a heavy concentration of a dark, black, greasy residue and food debris covering the surface of the grill and its sides. An interview with the Certified Dietary Manager (CDM) on 08/07/2012 at 4:35 PM revealed the grill was just used to prepare four (4) grilled cheese sandwiches for the dinner meal. The CDM stated that staff routinely wiped the grill after use with a wet cloth. On a weekly basis, staff would scrape off the greasy buildup and wipe the grill with a wet cloth. The CDM stated that a sanitizing solution was not used to clean the grill. The CDM confirmed that the grill should be cleaned and sanitized more frequently.	F 371		