STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

(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 156 SS=B	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	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. F-156 1. Residents #40 and #112 responsible parties were contacted on 11/14/2012 to confirm that they had received the Advanced Beneficiary Notice mailed by the facility Director of Social Services. They both confirmed that they had received the notification and confirmation of such was documented in their record under the Social Services tab. 2. Residents receiving Medicare benefits who have been discontinued from receiving those benefits from 10/1/12 to 11/15/12 have been reviewed by the Director of Social Services to confirm acknowledgement of receipt of the Medicare non coverage notice within 5 days of discontinuing Medicare coverage. Documentation of confirmed receipt was obtained from the notices that had not been received back in the facility. The Social Worker was educated by the Executive Director on the facility policy and procedure regarding Advanced Beneficiary Notices.	

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

Elizabeth M. Holland | Executive Director | 11/16/2012

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 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 includes a written description of the facility's	F 156	3. The Executive Director or Business Office Manager will conduct Quality Improvement (QI) monitoring of notification to the responsible party and/or resident of acknowledged receipt of the Medicare non-coverage notice 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. The Medicare non coverage notice will be sent via registered/return receipt requested mail in the event of failure to obtain signature within 5 days of Medicare A discontinuation. 4. The Executive Director/Designee will report results of QI monitoring to the Performance Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 11/28/2012	11/28/12

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F 156	Continued From page 2 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 documentation and staff interview the facility to acquire a acknowledged receipt of the Medicare provider non coverage notice for 2 of 3 sampled residents ' (Resident #40 and #112). The Non coverage notice identifies the resident ' s right to appeal the decision for discontinuation of physical, speech or occupational services under Medicare. The denial of payment under Medicare must be provided to the resident/responsible party in advance. The non-coverage notices identifies the right to appeal decision for services such as physical, occupational therapy, or speech services after the effective date indicated and services one may have to pay for any therapeutic services one received after the date Medicare A ends. The right to appeal decision identifies with a signature that the responsible person and/or individual had been notified that the coverage of services would	F 156		

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F 156	Continued From page 3 end on the effective date indicated on the notice and that they may appeal the decision by contacting the QIO(Quality Improvement Organization). The QIO is the independent reviewer authorized by Medicare to review the decision to end the services. 1. Resident #40 was admitted to the facility on 7/16/12. Her diagnoses included difficulty walking, joint contracture and abnormal posture. The Minimum Data Set(MDS) dated 9/12/12, indicated that Resident #40 had some short and long term memory and decision making problems. Resident #40 received occupational and therapy services. Review of the non-coverage notice identified the end of coverage date as 7/23/12 and the letter was mailed on 7/17/12. There was no signature that indicated that the responsible person or Resident #40 had been notified that the coverage of services would end on the effective date indicated on the notice and that they may appeal the decision by contacting the QIO(quality improvement organization). During an interview on 10/31/12 at 11:47AM, the business office manager indicated that the SW(social worker) was responsible for sending out the non- coverage letters. She indicated that once the date had been determined for discharge the treatment team would discuss the discharge plan and the SW would send the letters and follow-up with resident/family and inform BOM so that billing could be monitored during the appeal process. She indicated that she was unaware of when the notices were sent and the dates on BO file for Resident #40 indicated that end of services would be 10/18/12 and Resident #112	F 156		

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F 156	Continued From page 4 6/18/12. The non-coverage notices were reviewed and revealed the dates did not match what was on the financial file The BOM indicated she did not know what system the SW used to follow-up on whether the RP/resident received the notices. During an interview on 10/31/12 at 12:35PM, the SW indicated that non-coverage letters was sent for Resident #112 on 6/11/12(end of coverage (6/16/12), he did not have a signed copy of the letter nor was he sure the family/ resident received the letter. He indicated that he did not have a system in place to follow-up to ensure the letter was received or a signature obtained. Resident #40 end date 7/23/12 sent 7/17/12 there was no signature on document and SW indicated that he had not follow-up on whether the residents received the document. There was no response on the process to correlate the discharge dates with the BOM for billing purposes. 2. Resident #112 was admitted on 5/29/12 and discharged on 6/18/12. Her diagnoses included difficulty walking, general muscle weakness and rehabilitation services. The Minimum Data Set (MDS) dated 5/29/12, indicated that Resident #112 had no short or long term memory or decision problems. Resident #112 received occupational and physical therapy. Review of the non-coverage notice identified the end coverage date as 6/16/12 and the letter was mailed on 6/11/12. There was no signature that indicated that the responsible person or Resident	F 156		

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F 156	Continued From page 5 #112 had been notified that the coverage of services would end on the effective date indicated on the notice and that they may appeal the decision by contacting the QIO(quality improvement organization). During an interview on 10/31/12 at 11:47AM, the business office manager indicated that the SW(social worker) was responsible for sending out the non- coverage letters. She indicated that once the date had been determined for discharge the treatment team would discuss the discharge plan and the SW would send the letters and follow-up with resident/family and inform BOM so that billing could be monitored during the appeal process. She indicated that she was unaware of when the notices were sent and the dates on BO file for Resident #40 indicated that end of services would be 10/18/12 and Resident #112 6/18/12. The non-coverage notices were reviewed and revealed the dates did not match what was on the financial file The BOM indicated she did not know what system the SW used to follow-up on whether the RP/resident received the notices. During an interview on 10/31/12 at 12:35PM, the SW indicated that non-coverage letters was sent for Resident #112 on 6/11/12(end of coverage (6/16/12), he did not have a signed copy of the letter nor was he sure the family/ resident received the letter. He indicated that he did not have a system in place to follow-up to ensure the letter was received or a signature obtained. Resident #40 end date 7/23/12 sent 7/17/12 there was no signature on document and SW indicated that he had not follow-up on whether the	F 156		

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F 156	Continued From page 6 residents received the document. There was no response on the process to correlate the discharge dates with the BOM for billing purposes. During an interview on 10/31/12 at 3:13PM, the administrator indicated the expectation was the SW would send the non-coverage letters out certified and SW expected to follow-up to ensure the resident/family receives and make follow-up phone call. Review the Social worker notes for each of the residents neither resident had a note indicating the non-coverage notice was sent and whether the resident/RP received the information.	F 156		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain an environment in which there are no signs posted in residents' rooms that are visible where other residents and/or visitors can see confidential clinical or personal information for 24 of 52 sampled residents. (Resident #15, #74, #89, #43, #51, #37, #104, #85, #53, #57, #29, #18, #38, #19, #22, #80, #41, #62, #58, #71, #21, #72, #20, #88.)	F 241	F-241 1. The signage was removed from resident #15's room on 10/31/2012. Consents were obtained for residents 15, 74, 89, 43, 51, 37, 104, 85, 53, 57, 29, 18, 38, 19, 22, 80, 41, 62, 58, 71, 21, 72, 20, and 88 to have a falling star used as a part of the facility's fall risk program. Consents were also obtained for residents 74, 89, 43, 51, and 15 to have a hummingbird icon used as an identifier in the facility to alert staff of their dietary restrictions.	

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F 241	Continued From page 7 Findings include: On 10/29/2012 at 09:59:49 AM a sign was observed on the wall over the bed of resident #15. The sign identified the resident by name that read: "float heels when in bed. No shoes or Ted Hose To Right Foot The sign was observed as stated above on 10/29/12 at 3:00PM and on 10/30/12 at 10:00am. An interview with nurse #4 on 10/30/12 at 11:30am revealed that the sign on the wall over resident #15's bed was placed there by the nurses. On initial tour of the facility 10/28/12 at 9:30am a picture of a falling star was observed next to 21 residents name located next to the entrance to resident rooms. Resident #41, #62, #58, #71, #21, #72, #20, #88, #37, #104, #51, #85, #53, #57, #29, # 18, #38, #19, #22, #80, and #89 had a picture of a falling star next to their names. The falling star sign was observed on 10/29/12, 10/30/12 and on 10/31/12 next to resident names outside the entrance to their rooms. An interview with the Assistant Director of Nursing on 10/28/12 at 11:00am that signage was used for keeping resident safe and so new staff knew how to care for resident. A falling star indicates that resident is on the fall risk program. On the initial tour of the facility on 10/28/12 at 9:30am and on 10/29/12, 10/30/12 and on 10/31/12 a picture of a hummingbird was next to the name of 5 resident beside the entrance to their rooms. Resident #74, #89, #43, #51 and #15	F 241	2. An audit of current residents was completed by the MDS Coordinator and Dietary Manager to ensure consents were obtained for residents needing a care identifier 10/30/2012. The Interdisciplinary Team was educated by the Executive Director on the facility policy and procedure regarding Resident Care Identifiers and need for consent to be obtained at the time of implementation of care identifiers. The education will be provided to newly hired staff during the orientation process. 3. The DCS or Unit Manager will conduct Quality Improvement (QI) monitoring of new care identifiers to ensure consents have been obtained at the time of implementing the identifier 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. The DCS or Unit Manager will report results of QI monitoring to the Performance Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 11/28/2012	11/28/12

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F 241	Continued From page 8 were observed to have a picture of a hummingbird next to their names beside the entrance to their rooms. An interview with the ADON on 10/28/12 at 11:00am that signage was used for keeping resident safe and so new staff knew how to care for resident. A picture of a hummingbird indicated the resident was on nectar thick liquids.	F 241		
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, record review and staff interview, the facility failed to provide positioning for a resident in a wheel chair for one of 3 sampled residents. Resident #28) Findings included: Resident #28 was admitted to the facility on 10/3/11. Active diagnoses include Dementia, Parkinson, hypertension and depression. A review of the annual minimum Data Set dated 8/28/12 revealed resident has long and short term memory problems. Cognitive status was severely impaired. No range of motion limits were	F 309	F-309 1. Resident #28 is positioned in the wheelchair utilizing a pillow to prevent leaning to the left daily when out of bed. 2. An audit of current residents was completed by the DCS and Unit Manager on 11/16/2012 to identify residents are positioned appropriately in the wheelchair. Residents with wheelchair positioning concerns have been referred to therapy for screening. All nursing personnel were educated by the DCS or Unit Manager and/or Therapy Director on proper wheelchair positioning to include demonstration of proper positioning on 11/20/12. The facility department managers have been educated on proper wheelchair positioning on 11/16/2012. This education will be presented to newly hired staff during the orientation process.	

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F 309	Continued From page 9 identified. Bed mobility was with extensive assist with one person. Activities of daily living require extensive assist with 1 person. A review of the current care plan dated 9/10/12 identified a problem of fragile skin prone to skin tears. The interventions included reposition every round and as necessary and use pillows or other supportive/protective devices to assist with positioning. A review of the kardex used by the nursing aides providing care for Resident #28 identified she was to be repositioned every 1 to 2 hours. On 10/29/12 at 10:23am Resident #28 was observed sitting in a wheel chair leaning to the left side of chair, a family member placed a pillow in the wheel chair to straighten resident up. He stated that she is always leaning and the staff do not always put the pillow in place. On 10-3012 at 9:45Am resident was observed sitting next to her bed in a broda wheelchair. She was leaning toward the left side of the chair with her head resting against the side of the chair; there was no positioning device in place. On 10/31/12 at 11:20am Resident #28 was observed sitting in a broda wheelchair next to the bed leaning to left with her head resting on side of chair; no positioning device was in place. A review of the physician orders revealed a order listed on the October 2012 monthly pre-printed order sheet with an original date of 12/19/11 that read may use neck collar for head positioning. An interview with the nurses aide (NA) #1 on 10/31/12 at 10:31am revealed that she provided care daily for Resident #28. NA#1 indicated that	F 309	The department managers will monitor wheelchair positioning during daily monitoring rounds. The Customer Care Liaison will monitor wheelchair positioning on weekends. 3. The DCS or Unit Manager will conduct Quality Improvement (QI) monitoring of proper wheelchair positioning 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. The DCS/Designee will report results of QI monitoring to the Performance Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 11/28/2012	11/28/12

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F 309	Continued From page 10 she positioned resident every 2 hours. Further discussion revealed that a pillow was used to put on her side and she had a neck brace to help position her in the wheelchair. "I do not put them on when she is active, she will use them to try and stand up. I only put them in when she is sleeping."	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, the facility failed to provide a diagnosis and order for the use of a urinary catheter for one of two residents with urinary catheters (Resident #39). Findings include: Resident was admitted to the facility 1/13/12 and readmitted on 3/9/12. Cumulative diagnoses included: Diabetes Mellitus, Hypertension, Chronic pain syndrome and history of prostate cancer. Diagnoses also included the use of an indwelling urinary catheter (suprapubic catheter). A Significant Change Minimum Data Set (MDS)	F 315	F-315 1. A diagnosis of Urinary Retention was received for resident #39 on 10/31/2012. 2. Current residents with urinary catheters have been reviewed to ensure there is a diagnosis supporting continued catheter use and an order for use in place. Current licensed nurses were educated on the acceptable clinical condition to utilize a urinary catheter and need for physician order to care for the urinary catheter. 3. The DCS or Unit Manager will conduct Quality Improvement (QI) monitoring supporting documentation and orders for caring for the urinary catheter 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. New admission charts and telephone orders will be reviewed daily to identify any new orders related to urinary catheters.	

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F 315	Continued From page 11 dated 3/16/12 indicated Resident #39 displayed mild cognitive impairment. The use of an indwelling urinary catheter was noted on the MDS. A Quarterly MDS dated 9/5/12 indicated Resident #39 had an indwelling urinary catheter. A Care plan dated 3/28/2012 and last reviewed 9/17/12 indicated Resident #39 used an indwelling urinary catheter. Approaches included: ongoing assessment of color, clarity and character of urine; ongoing assessment for symptoms of urinary tract infection; change catheter and tubing every 4 weeks; secure tubing to thigh to prevent pulling, catheter care every shift; encourage fluid intake; monitor tubing for kinks or twists in tubing. On 7/30/12, a physician's progress note indicated Resident #39 had blood tinged urine and small blood clots in the urinary drainage bag. Urology: change indwelling catheter, irrigate bladder, hematuria (blood in urine) secondary to catheter trauma with movement. A review of Resident #39's physician's orders revealed there was not a physician's order for the indwelling urinary catheter (suprapubic catheter). A review of the medical record revealed there was not a specific diagnosis related to the use of the indwelling urinary catheter. No urology consults were noted in the medical record. On 10/29/12 at 10:56 AM., Resident #39 stated he had a lot of blood clots and could not void on his own so they put a catheter in his bladder.	F 315	Education will be provided to newly hired licensed nurses during the orientation process. 4. The DCS/Designee will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 11/28/2012	11/28/12

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	345436	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

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F 315	Continued From page 12 On 10/31/12at 9:59 AM., Resident #39's primary physician stated Resident #39 had chronic hematuria (blood in urine) and problems with obstruction due to prostate cancer history. He further indicated he would recommend the indwelling catheter be changed on an "as needed" basis. Resident #39's physician said he was unaware there was not a physician's order for the indwelling catheter or for the catheter to be changed as needed by the nursing staff. On 10/31/12 at 5:15 PM., the Director of Nursing stated there should be a physician's order for the use of the indwelling catheter (suprapubic catheter).	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	F-329 1. Resident # 15 and # 74 antipsychotic medication has been discontinued by the physician. 2. Current residents receiving antipsychotic medications have been reviewed by the Director of Clinical Services and Unit Manager. An audit was completed to ensure there was a diagnosis supported for continued use of the medication and need for risk versus benefit statement for continued use of an antipsychotic medication without a dose reduction. Three gradual dose reductions and eight eliminations were initiated by the physician on 11/16/2012. Current licensed nurses were educated on the requirement of	

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F 329	Continued From page 13 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to have a diagnoses for the use of antipsychotic medication (Respirdal) and Seroquel) for 2 of 10 residents. (Resident #15 & 74) The facility also failed to have documentation which included the benefits versus the risk for continued use of an antipsychotic medication with out a dose reduction for 1 of 10 sampled residents. (Resident #15 & #74) Findings include: Resident #15 was admitted to the facility on 8/10/12. Diagnoses included but not limited to hypertension, cardiovascular accident, contracture right hand, dysphagia, hiatal hernia, anemia, abnormal posture, depression and anxiety. A review of the physician orders for the month of October 2012 revealed an order for Resperidal 0.25mg take 1 tab daily. The original date of order was 1/30/12. A review of Resident #15's medical record had no documentation of a diagnoses for the use of Respirdal.	F 329	appropriate diagnosis with behavior monitor on 11/20/12. 3. The DCS or Unit Manager will conduct Quality Improvement (QI) for new orders for antipsychotic medications received 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. The consultant Pharmacist will review diagnosis and gradual dose reductions of residents receiving antipsychotic medications monthly and report discrepancies to the attending physician. 4. The DCS or Unit Manager will report results of QI monitoring to Performance Improvement Committee monthly x 12 months for continued compliance and/or revision. The consultant Pharmacist will report to the committee quarterly on compliance to diagnosis and gradual dose reduction. 5. Date of completion 11/28/2012	11/28/12

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F 329	Continued From page 14 An interview with the director of nursing on 10/31/12 at 1:00pm revealed that she did not see a diagnoses or medical justification in the residents chart for the use of Respirdal. Resident #74 was admitted to the facility on 3/8/12. The active diagnoses were listed as hypertension, dementia and depression. A review of the current physician orders for the month of October 2011 revealed an order for Seroquel 25mg every hours of sleep (hs). A review of the medical record revealed the resident was admitted to the facility on Seroquel. Further review of the medical record revealed there was no documentation of a diagnoses for the use of Seroquel. An interview with the assistant director of nursing on 10/31/12 at 3:15pm confirmed there was no diagnoses for the use of Seroquel. The assistant director of nursing indicated that she had reviewed the residents medical record and there was diagnoses available. 2. Resident #15 was admitted to the facility on 8/10/12. Diagnoses included but not limited to hypertension, cardiovascular accident, contracture right hand, dysphagia, hiatal hernia, anemia, abnormal posture, depression and anxiety. A review of the medical record for Resident #15 revealed a pharmacy consultation report dated 8/11/12 that recommended a dose reduction for the Respirdal. The physicians' response was that the daughter indicated the resident was	F 329		

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F 329	Continued From page 15 hospitalized after changers in medication and she refused any further reduction in dosing of medication. The response also stated this discussion was done via a phone call. Further review of the medical record revealed there was no documentation of the benefits out weighted the risks in the use of Respirdal was available. An interview with the director of nursing on 10/31/12 at 1:00pm revealed that she could not find any documentation in Resident #15's chart indicating the benefits of the use of Respirdal out weighted the risks associated with the medication.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to	F 356	F-356 1. Daily staffing with accurate information is posted daily. 2. No residents were identified. 3. The Director of Clinical Services, Unit Manager, was educated to the requirements of posting accurate, complete staffing information to include census on a daily basis by the Nursing Home Administrator. The Weekend Supervisor and licensed nurses were educated regarding posting of daily staffing by the Director of Clinical Services and/or Unit Manager 4. A quality improvement tool will be completed by the Nursing Home Administrator or designee daily 5x/week x 2 weeks, then 3x/week x 2 weeks, then weekly x	

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F 356	Continued From page 16 residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to have the daily staffing hours posted in the facility for 1 of 1 required posting. Findings include: On 10/28/12 during the initial tour of the facility no daily staffing hours were observed posted within the facility. On 10/29/12. 10/30/12 and the morning of 10/31/12 no staffing hours were observed posted within the facility. On 10/28/12 at 11:50am the Assistant Director of Nursing brought in a daily staffing sheet to the conference room. An interview with the Director of Nursing on 10/30/12 at 2:00pm revealed that the daily staffing hours were usually posted daily She also stated that the staffing hours was reviewed daily in the facility stand up meeting, however they have not had a stand up meeting like they normally do this week and she did not realize it was not posted..	F 356	4weeks and then one time monthly for 9 months to ensure daily staffing posting is accurate and complete. 5. The Nursing Home Administrator or designee will report the results of the Quality Improvement tool to the Performance Improvement committee monthly x 3 months to identify trends and need for further education and/or monitoring. Date of completion 11/28/2012	11/28/12

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	345436	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/27/2012

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 1/27/2012 there were holes around pipes penatrating the ceiling in thesprinkler riser room and the kitchen water heater room. 42 CFR 342.80 (a)	K 012	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. K012 1. The Maintenance Director added fire caulking and dry wall around the pipes in the sprinkler riser room and the kitchen water heater room on 12/18/2012.	12/18/12
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	2. An audit was completed by the Maintenance Director to ensure that all areas around the hot water heaters were sealed to meet code K012. 3. The Maintenance Director will conduct Quality Improvement (QI) monitoring of this standard 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 12/31/2012. K018 1. The Maintenance Director enlarged the latch on the MDS office door so it will latch in accordance with K018 on 12/18/2012.	12/31/12 12/18/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth M. Holland	Executive Director	12/18/2012

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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K 018	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 11/27/2012 the door to the MDS office failed to latch. 42 CFR 483.70 (a)	K 018	2. An audit was completed by the Maintenance Director to ensure That all doors latched in accordance with K018. 3 The Maintenance Director will conduct Quality Improvement (QI) monitoring of this 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4 The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5 Date of completion 12/31/2012.	12/31/12
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 11/27/2012 the facility had no records of a five (5) year obstruction test for the dry sprinkler system. 42 CFR 483.70 (a)	K 062	K062 1. A 5 Year Obstruction Test is scheduled for 12/20/2012. 2 An audit was completed by the Maintenance director to ensure All other tests required to the sprinkler system had been scheduled. 3. The Maintenance Director will conduct Quality Improvement (QI) monitoring of this standard 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 12/31/2012.	12/20/12 12/31/2012

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