

MAY 14 2013

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2013
NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27026	
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F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record reviews, the facility failed to identify medical symptoms for 5 of 7 sampled residents with restraints and failed to implement systematic approaches to reduce restraints(Residents #117, #162, #85, #189, and #69). The findings included</p> <p>A review of the facility ' s policy on Physical Restraint Devices dated 8/2012 included (in part) the following: " Restraint use in the facility will only be considered to treat medical symptom(s) that endanger the physical safety of the resident or other residents and under the following conditions:</p> <p>1) The decision to apply physical restraints should be based on a written evaluation of resident ' s capabilities in context with the resident ' s condition, circumstances, and environment.</p> <p>2) Evaluation will show the presence of a specific medical symptom or reason why the restraint is required and how the benefit of usage outweighs the identified risks.</p> <p>3) Validation of the evaluation will occur by the designated RN. Documentation should include evaluation of the least restrictive and alternative methods tried and the ruling</p>	F 221	<p>Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, JCNRC reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F221</p> <p>All current residents to include Residents #117, #162, #85, #189, & #69 were all reassessed on 5/8/2013 by QI nurse for the continued need of physical restraint use with accurate documentation to include medical symptoms completed .</p>	5/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shawn Kistler* TITLE Administrator (X6) DATE 5-9-13

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 221	<p>Continued From page 1</p> <p>out of their use after being proven unsuccessful.</p> <p>4) A physician ' s order will be obtained indicating type of restraint used and medical symptom(s) for which the restraint is used.</p> <p>5) Consent of the resident (or legal representative) after discussion of potential positive and negative outcomes from usage. "</p> <p>1. Resident #117 was admitted to the facility on 4/8/2010 . Resident #117 cumulative diagnoses included hypertension, coronary artery disease, failure to thrive, mental disorder, dementia and general muscle weakness. The annual Minimum Data Set (MDS) dated 10/4/12, indicated that Resident #117 had severe short and long term memory and decision making problems. The MDS also indicated that Resident #117 needed assistance with all activities of daily living, transfers and ambulation. Resident #117 did not exhibit any behaviors during the assessment period. Resident #117 required two person assistance and the use of a lift. Review of the falls risk assessment dated 9/28/11 to current revealed that Resident #117 had not had any falls due to the use of the posey belt</p> <p>Review of the care plan dated 10/4/12, identified the use/application of physical restraint device to prevent injury to self characterized by high risk for injuries/ falls, impaired mobility related to unsteady gait, muscle weakness. The goals included resident would have no injury from falls. Interventions included discuss the necessity of restraining device for resident with resident family, evaluate device for least restrictive, reduction and/or discontinuation per facility protocol, evaluate and treat for underlying causes</p>	F 221	<p>Retraining was conducted by Staff Facilitator on the Physical Restraint Policy with all nursing staff and completed on 5/14/2013. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p> <p>Audits will be conducted by QI nurse on a weekly basis to ensure any resident requiring restraint use and to include Residents #117, #162, #85, #189, & #69 has the correct documentation reflecting medical symptoms with reductions conducted at least quarterly and as needed utilizing a QI tool. These audits will be turned into the Administrator weekly for review. Any identified concerns will be addressed at that time QI nurse. The Executive QI Committee will review audits weekly x 4, monthly x 2 and on a Quarterly basis x 3 for follow up on any potential or identified concern and to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time QI nurse.</p>	

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F 221	<p>Continued From page 2</p> <p>of potential falls, injury, to be in rock-n-go with posey belt when OOB(out of bed), remove device during provision of care and re-apply upon completion. 2. she required assistance/potential to restore or maintain max function of self sufficiency for mobility characterized by the following functions: positioning, locomotion, ambulation related to at risk limitation ROM (range of motion) in upper/lower extremities. The goals included the resident would have no limitations of ROM of Upper/lower extremities as AEB (as evidence by) no contractures. Interventions included AROM (active range of motion) group 3-6xwk, if resident did not participate in restorative group AROM exercise document reason. The goal was resident would walk 100 ft or more with RW (rolling walker) 3-6xwk and 1 person assistance, if did not participate document reason.</p> <p>Review of the care area assessment for restraint dated 10/10/12, documented the impaired mobility related to unsteady gait, discussed the necessity of restraining device for resident with resident/family. Evaluate device for least restrictive, reduction and/or discontinuation per facility protocol. To be in rock-n-go with posey belt when out of bed. Toilet/provide incontinent care as required by resident and as needed. Resident #117 would not fall till next review.</p> <p>Review of the physician s order dated 8/20/10, documented out of bed in rock n go with posey belt due to unsafe movements. There was no medical symptom indicated. Resident #117 has been in restorative passive/active range of motion and restorative ambulation, 3-6 times a week since April 27, 2012.</p>	F 221			

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F 221	Continued From page 3 Review of physician's progress note dated 2/3/13, revealed Resident #117 was alert and cheerful was incontinent and wheelchair bound, nursing didn't notice her having any problems. There was no documentation indicating the use of the posey restraint or restraint reduction or medical symptoms for the use of the restraint in the physician's notes. There were no notes indicating that there was a concern with the resident leaning or having any positioning problems. Additional, review of the behavior notes dated 4/9/13, did not indicate any behavior or agitation problems. Review of nursing notes dated 12/4/12 through 4/16/13; revealed Resident #117 was treated for routine healthcare issues. There were no indications from nursing or behavior notes that Resident #117 had not demonstrated any concerns with leaning forward and/or in any other direction, nor did the notes indicate any behavior concerns. Resident #117 remained alert with confusion and no signs of distress. Resident #117 was able to transfer with pivot stand for all transfers. Review of the care plan-general note for restraint documentation from 8/20/2010 to 4/3/2013, revealed that family made request for the use of the posey belt(2010) and there had been no reassessment for any other type of alternative device since implementation. The notes routinely indicated that when the posey belt was released Resident #117 would lean forward in an attempt to reach for items within reach, attempt to use the handrail or reach down toward feet/foot pedal for	F 221			

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F 221	<p>Continued From page 4</p> <p>items and this was unsafe movements. There were no other assessments presented that indicated that Resident #117 had been reassessed by physical therapy or the physician had reviewed medical condition changes or attempts for least restrictive device, restraint alternatives or reduction. The care plan dated 10/4/12 indicated the device should be released during care and re-apply upon completion. Additional, review of the notes did not include they type of assessment used and duration of the assessment to determine the effectiveness or need for continuation of the device.</p> <p>Review of the social work notes dated 4/11/13, revealed there was no discussion with responsible person regarding the continuation of the posey belt.</p> <p>During an observation on 4/16/13 at 10:47AM, Resident #117 was seated at nursing station in wheelchair with chair slightly reclined back with posey belt restraint in place around her waist and tied to back of chair. There were no repetitive movements in any directions. Resident#117 was very quiet/calm and staring into space.</p> <p>During an interview on 4/16/13 at 10:57AM, social worker #2(SW) indicated that she had not had any discussions with the family about the risk factors for the use of the posey belt during Resident #117 recent care plan meeting. She added that the family had requested the use of the posey belt due to their fear of Resident #117 falling some time ago. She indicated that the family requested the use of the belt due to the resident leaning, but she had not seen the behavior of the resident leaning. Resident#117</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>was generally alert and confused and quiet at nursing station. Resident#117 was unable to release. SW#2 indicated that she had no noted documentation of the resident leaning or having any positioning problems.</p> <p>During an observation on 4/16/13 at 3:00PM, Resident#117 was seated on the hall at the nursing station sleep with posey belt restraint tied around her waist and to the back of the chair and the chair reclined back. Resident #117 was awakened by noise and was very confused and unable to comprehend the conversation or the use of the restraint. There were no repetitive movements in any direction</p> <p>During an observation on 4/17/13 at 8:37AM, Resident#117 chair was slightly reclined back and she was seated in the dining room eating her breakfast in restorative feeding self with posey belt tied to around her waist and to the back of the chair. She required cueing to get started with her meal from the restorative aide.</p> <p>During an interview restorative aide #1(RA) indicated that Resident#117 wore the posey belt 24 hours unless she was toileted. Resident #117 ate meals and participated activities in the restraint. She has not attempted to get up from chair in bout a year. Resident#117 leaned forward to play with her shoes and needs assistance to reposition self. The chair was kept in a slight recline position to help prevent resident from leaning forward. Resident#117 could propel wheelchair with her hands on occasion. Resident#117 generally sat at nursing station and</p>	F 221		

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F 221	<p>Continued From page 6</p> <p>staff would periodic walk her. RA#1 indicated that Resident#117 had the restraint more than a year. Therapy had not worked with resident in the past year and resident did not have any falls. She resident did not have any repetitive behaviors or movements, she was pretty much stationary. Resident#117 also had padded wings cushion pillows which helps reduces the leaning to the side position when she sleeps.</p> <p>During an interview on 4/17/13 at 8:57AM, Nurse #3 indicated that Resident #117 liked to lean forward to pick up things from the floor or in her area of space. He indicated that family requested that the belt be put into place. He added that there was no clinical reason for the use of the belt other than safety and to prevent her from falling. He added that the Resident#117 had not falling in years and it remains in place all day unless personal care was provided. Resident#117 ate meals in restraint and participated in activities. The alarm was added to alert the staff of when the Resident#117 attempted to get up, but she generally was stationary in the chair. She does not have any repetitive movements or behaviors. He added that it was an enabler to prevent falls.</p> <p>During an interview on 4/17/13 at 9:09AM, QI Nurse indicated she was responsible for assessing the restraints indicated that the posey belt was a restraint . Resident##17 leaned forward and on right side, to pick up things off the floor. QI Nurse stated that her leaning over was unsafe. Resident#117 would also grab onto the handrails gets to hand rail attempts to scoot or pulled herself up down the hall. Resident#117 had the restraint on mainly due to her leaning and there was no medical reason for the use of the</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>restraint. She added that she had it for a long time and there had been no change. Resident#117 did not have any repetitive behaviors. She added that there were no other devices attempted other than to apply the position pillow. Review of the restraint evaluation revealed per QI Nurse that there was no alternative device attempted to eliminate and/or reduce the use of the restraint. Resident #117 had not been assessed by therapy nor was there other interventions applied or tried.</p> <p>During an observation on 4/17/13 at 9:41AM, Resident#117 was seated at the nursing station restraint sleep in wheelchair with posey belt around waist and tied to back of the reclined chair.</p> <p>During an interview on 4/17/13 at 9:46AM, physical therapy manager(PTM) indicated that Nurse#11 was responsible for doing the assessment for restraints. PTM indicated there was no current restraint reduction program. The therapy department did not routine screen or evaluate residents for restraints unless they were currently been seen by the department staff. The nursing department handled the assessment, evaluation and determination for the use of restraints and she was unaware of the specific process currently being used to assess and determine which residents would need restraints. Therapy was responsible for assessments referred due to falls or other mobility/transfer changes.</p> <p>During observation an interview on 4/17/13 at 12:10PM, Resident#117 observed seated at the nursing station with baby doll in hand and</p>	F 221			

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F 221	<p>Continued From page 8</p> <p>wheelchair slightly reclined backed with posey belt in place. Nurse#9 indicated that the Resident#117 was in restraint due to leaning and poor safety awareness. She indicated that the resident family also requested that the restraint be applied to prevent the resident from falling.</p> <p>During an interview on 4/17/13 at 4:30PM, Nurse#10 indicated that posey belt restraint was in place as a family request because they thought she lean over to far when she reached for items. Nurse#9 added that Resident#117 did not demonstrate any other behaviors that she was aware of. Resident#117 was able to self propel wheelchair with hands</p> <p>Resident#117 was seated in room with chair slightly reclined back and posey belt restraint in place next to her bed. She was able to slightly reach for the crochet blanket on her bed. She was confused but pleasant.</p> <p>During an interview on 4/17/13 at 4:50PM, NA#10 indicated that the family requested that the belt remain in place to prevent the resident from falling and because the resident leans to reach over to play with her shoes. He added that when Resident#117 was redirected with activities or playing with her baby doll she forgets about her shoes. He added that Resident#117 did not have any other behaviors and that ambulation was suppose to be done on 1st shift through the restorative program. He further stated that Resident #117 wore the restraint at all times unless in the bed or care was being provided.</p> <p>During an observation on 4/18/13 at 9:08AM,</p>	F 221			

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F 221	<p>Continued From page 9</p> <p>Resident#117 in dining room with restraint in place.</p> <p>During an observation on 4/18/13 at 10:001AM, Resident#117 was moved to the back of the facility with a small group of residents to listen to music and the posey belt remained around the waist with chair reclined back and tied to the back of the chair during the activities.</p> <p>During a family interview on 4/18/13 at 10:53AM, the family member indicated that since the Resident #117 had dementia she did not want her to fall. She requested the belt, because the she reached for items out of reach and her cognition prevented her from understanding that she could not reach for the items. It was her that the Resident#117 would fall and get injured as had done in the past.</p> <p>2). Resident #162 was admitted to the facility on 7/11/2012. Resident #162 diagnosis included dementia and fractured femur resulting from a fall.</p> <p>A discharge assessment dated 11/15/2012 and 1/11/2013 indicated the resident had memory problems.</p> <p>The record review indicated that the resident had fallen on 1/13/2013 and fractured her left femur. The resident returned to the facility on 1/15/2013. On 1/16/2013 nurse #11 updated the care plan to include " Use/application of physical restraint</p>	F 221		

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F 221	<p>Continued From page 10</p> <p>device for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility, physical aggression related to: unsteady gait, Left hip fracture. "</p> <p>The review of the care plan dated 2/7/2013 identified the use/application of a physical restraint device for prevention of injury to self or to others characterized by high risk for falls with problems in decision making related to progressive decline in intellectual functioning characterized by memory problems.</p> <p>A record review revealed the facility had assessed Resident # 162 on her most recent MDS dated 3/15/2013 as severely cognitively impaired. There were no restraints indicated.</p> <p>The resident was observed on 4/16/13 at 11:00 AM with a soft belt restraint that had a double hook, plastic clasp located in the front of it. The back of the belt restraint was criss-crossed in the back and secured by loop straps at the end of the restraint to bars that extended out the back, base of the wheelchair.</p> <p>The resident was observed on 4/17/13 at 08:00 AM with a soft belt restraint that had a double hook, plastic clasp located in the front of it. The back of the belt restraint was criss crossed in the back and secured by loop straps at the end of the restraint to bars that extended out the back, base of the wheelchair.</p> <p>An interview with nurse #11 on 4/17/13 at 09:00 AM revealed that the restraint belt was an enabler that kept the resident from falling. Nurse #11 stated that if the resident couldn ' t self release</p>	F 221			

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F 221	<p>Continued From page 11</p> <p>the belt then it would be considered a restraint.</p> <p>On 4/17/13 at 11:00 AM NA #6 said the Resident#162 could release the seatbelt. When NA #6 asked Resident #162 to undo her seatbelt, Resident #162 just stared at NA #6. NA #6 attempted to cue Resident #162 on where the belt buckle was and what to push to release it. Resident #162 looked down at the where NA #6 was pointing and looked back up to NA #6 and said " What? "</p> <p>The resident was observed on 4/18/13 at 08:00 AM and 09:00 AM with a soft belt restraint that had a double hook, plastic clasp located in the front of it. The back of the belt restraint was criss crossed in the back and secured by loop straps at the end of the restraint to bars that extended out the back, base of the wheelchair.</p> <p>An interview with nursing assistant (NA) #5 and nurse #3 on 4/18/13 at 09:22 AM indicated that the restraint belt was to help keep the resident from falling. Nurse #3 stated that Resident #162 had a habit of leaning forward and picking things up off the floor and would fall out of her chair.</p> <p>Resident #162 started physical therapy upon return to the facility to increase bed mobility and transfers. Interview with physical therapy assistant on 4/19/13 at 8:40 AM indicated that the resident was released from physical therapy on 4/5/2013 because she required " less assistance " with mobility and transfers.</p> <p>During an interview with the Director of Nursing on 4/19/13 at 12:30 PM she stated her expectation was that no residents were restrained</p>	F 221			

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F 221	<p>Continued From page 12 against their will.</p> <p>3.) Resident #189 was admitted on 12/6/2012 with diagnosis including fracture to her left femur, hypertension and dementia. The Minimum Data Set (MDS) dated 12/13/2012 indicated that Resident #189 had a short term and long term memory problem. The MDS dated 12/21/2012 stated that Resident #189 was severely cognitively impaired and combative with care and to others. Resident #189 required extensive assistance with activities of daily living (ADL) and toileting with one person assist.</p> <p>The record review of the MDS dated 2/26/2013 indicated that Resident #189 was severely cognitively impaired. The resident required extensive assistance of one person for ADL ' s.</p> <p>The record review indicated a Physician ' s order dated 4/15/13 for a reclined, high back chair " when out of bed due to unsafe movements "</p> <p>During an observation of Resident #189 on 4/16/13 at 4:30 PM, the resident was noted to be in the hallway in a wheelchair that could not be self-propelled, with a high back, foot ledge and a dining tray that could not be removed without assistance of a staff member. The resident was agitated and attempting to push the tray table off.</p> <p>During an interview on 4/16/13 at 4:45 PM, the Restorative Nurse stated that they had tried a rocking specialty wheelchair with the resident in addition to a pommel cushion in place to keep Resident #189 from getting out of the chair. The Restorative Nurse stated that they had to go back to using the high backed chair with a tray</p>	F 221			

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F 221	<p>Continued From page 13</p> <p>because Resident #189 had poor safety awareness and that the tray table was used to keep her from getting up and hurting herself.</p> <p>An interview with Quality Improvement (QI) Nurse on 4/17/13 at 9:26 AM revealed that the resident was in the locked chair with a tray table because Resident #189 had poor safety awareness and " would get hurt if we left her out of it since she likes to get up and move around unassisted. " The QI nurse stated that Resident #189 ' s tray table had a restraint to keep her safe.</p> <p>During an observation on 4/17/2013 at 4:00 PM, Nurse Aide (NA) #11 stated that Resident #189 was in reclined wheelchair to prevent her from falling.</p> <p>On 4/18/2013 at 7:30 AM, Resident #189 was sitting in a high backed, non-self propelling wheelchair with a tray table securely in place. Resident was pushing and banging on the table. At 7:46 AM the resident became very agitated and reclined the chair all the way back so that the foot portion of the chair touched the bottom side of the tray table. The resident was no longer able to keep her legs below the tray table and had her legs over the side of the reclined chair yelling that she wanted out of the chair. NA# 8 and Nurse #8 returned the chair to an upright position and placed the tray table back in place in front of the resident.</p> <p>During an interview on 4/18/2013 at 10:00 AM, NA #8 stated that the resident walked pretty well with staff but the tray table was used to keep her in her chair because, " I don ' t want her to get up. "</p>	F 221			

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F 221	<p>Continued From page 14</p> <p>During an interview on 4/19/2013 at 12:30 PM, the Director of Nursing stated that her expectation was that no residents were restrained against their will.</p> <p>4.) Resident #85 was admitted to the facility on 3/31/2010. Resident #85 ' s diagnoses including Alzheimer ' s disease, and lack of coordination.</p> <p>Review of the care area assessment dated 9/3/2012 showed that Resident #85 was cognitively impaired, at risk for falls, behaviors noted but no restraints observed at time of the assessment.</p> <p>Resident #85 ' s Minimum Data Set (MDS) dated 2/26/2013 stated that the resident was severely cognitively impaired. The MDS also indicated that Resident #85 needed assistance with all activities of daily living, transfers and ambulation. The resident was not assessed to have restraints.</p> <p>The review of Resident #85 ' s care plan dated 2/27/2013 indicated the resident was care planned for the risk for falls with the goal that Resident #85 would not sustain serious injury through next review. Interventions put in place included that the resident would be in wheelchair with alarming self release belt when out of bed, to be used as an enabler.</p> <p>During an observation of Resident #85 on 4/16/2013 at 12:30 PM the resident was noted eating lunch in the dining room with a self release seat belt on.</p>	F 221			

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F 221	<p>Continued From page 15</p> <p>During an interview on 4/17/13 at 8:55 am, nurse #8 indicated that the belt was for the resident ' s safety. Nurse #8 stated that the resident had become increasingly more unstable on her feet so they put her in the self release belt alarm.</p> <p>Resident #85 was observed sitting in her wheelchair 4/17/2013 at 9:00 AM with the self release belt on and attempting to stand up next to the nurses med cart. The Resident was mumbling and did not attempt to undo seatbelt while she was trying to get up. Nurse #8 asked the resident to undo self release seatbelt and Resident #85 placed her hands on the seatbelt but was unable to release the belt.</p> <p>During an interview on 4/17/13 at 9:26 AM, the Quality Improvement (QI) nurse indicated that Resident #85 was placed in the self release seat belt because she was having falls and her gait was unsteady on 2/11/13. The QI nurses stated that Resident #85 was ambulatory but she was unsafe to do so. The QI nurse also stated that an enabler was a self release alarm and if the resident couldn ' t release the belt, then it is a restraint. The QI nurse stated that the enabler was enabling Resident #85 not to fall.</p> <p>During an interview on 4/17/2013 at 10:30 AM, Nurse Aide (NA) #6 stated that Resident #85 went through periods of agitation where she attempted to get up on her own and could fall down. Resident #85 was asked to release her seatbelt by NA #6. The resident fumbled around with the belt, NA #6 placed resident ' s hands over the release button and told her to push. The resident became very agitated and was unable to</p>	F 221			

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F 221	<p>Continued From page 16 release the belt.</p> <p>During an interview on 4/17/2013 at 3:50 PM, the Administrator stated that the facility did not have a policy on the use of enablers.</p> <p>During an interview on 4/17/13 at 4:30 PM, Nurse #6 stated that Resident #85 wore the belt to keep her from falling. Nurse #6 also stated that the resident had become unsteady on her feet. Nurse #6 also stated that she has not seen Resident #85 release the belt on her own.</p> <p>Resident #85 was observed on 4/18/13 at 12:30 PM eating lunch in the dining room. The resident 's seatbelt alarm was secured at that time.</p> <p>During an interview on 4/19/13 at 12:30 PM, the Director of Nursing stated that her expectation was that no residents would be restrained against their will.</p> <p>5. A review of the facility 's policy on Physical Restraint Devices dated 8/2012 included (in part) the following: " Restraint use in the facility will only be considered to treat medical symptom(s) that endanger the physical safety of the resident or other residents and under the following</p>	F 221		

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F 221	<p>Continued From page 17</p> <p>conditions:</p> <ol style="list-style-type: none"> 1) The decision to apply physical restraints should be based on a written evaluation of resident ' s capabilities in context with the resident ' s condition, circumstances, and environment. 2) Evaluation will show the presence of a specific medical symptom or reason why the restraint is required and how the benefit of usage outweighs the identified risks. 3) Validation of the evaluation will occur by the designated RN. Documentation should include evaluation of the least restrictive and alternative methods tried and the ruling out of their use after being proven unsuccessful. 4) A physician ' s order will be obtained indicating type of restraint used and medical symptom(s) for which the restraint is used. 5) Consent of the resident (or legal representative) after discussion of potential positive and negative outcomes from usage. " <p>Resident #69 had cumulative diagnoses including Alzheimer ' s disease, unspecified debility, muscle weakness (generalized), and personal history of falls. A review of incident reports from the past six months revealed the resident had 3 falls, including a fall on 10/4/12 (with an abrasion noted to her left upper arm), 11/3/12 (with a bruise/ecchymosis noted to her right upper arm), and 12/15/12 (with no injury noted). A review of Resident #69 ' s medical record revealed February 2013 ' s Monthly Physician Orders included the following Safety Device Order (not dated): " To be in wheelchair with alarming self-release belt applied when out of bed to be used as an enabler to aide with safe sitting posture. " Resident #69 ' s most recent quarterly</p>	F 221		

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F 221	<p>Continued From page 18</p> <p>Minimum Data Set (MDS) dated 3/13/13 indicated she had moderately impaired cognitive skills for daily decision making. Wandering behaviors and physical behavior symptoms not directed toward others were noted to have occurred on a daily basis during the assessment period. The MDS also revealed Resident #69 required extensive assistance with most Activities of Daily Living (ADLs), including bed mobility, transfers, toileting and personal hygiene. Resident #69 was noted to have the ability to independently propel herself in the wheelchair throughout the facility.</p> <p>Resident #69 's care plan dated 3/25/13 included the resident 's risk for falls as an area of focus. The risk for falls was noted to be characterized by a history of falls/actual falls, injury, and multiple risk factors related to impaired mobility and decreased safety awareness. Care plan interventions addressing Resident #69 's risk for falls included: 1) " To be in Wheelchair with Alarming Self Release Belt applied when out of bed, to be used as an enabler to aide with safe sitting posture " initiated on 3/29/12 and revised on 4/17/13; and 2) "High Winged Mattress (a mattress with a raised perimeter) to low bed " initiated on 4/5/12 and revised on 12/17/12.</p> <p>On 4/16/13 at 9:50 AM, Resident #69 was observed sitting in her wheelchair with an alarming seat belt in place. An interview was conducted with NA (Nurses' Aide) #6 at that time. NA #6 reported the seat belt was a "self-release belt" with an alarm in place. The nurses aide reported the resident was able to remove the seat belt.</p> <p>On 4/16/13 at 2:20 PM, observed Resident #69</p>	F 221		

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F 221	<p>Continued From page 19</p> <p>sitting in her wheelchair with an alarming seat belt in place. During the follow-up interview with NA #6, the nurses ' aide stated the seat belt was an "enabler" and intended to keep the resident safe. When NA #6 asked the resident to remove the belt, she stated, "I can't do it " multiple times. Resident #69 was not able to release the seat belt upon request.</p> <p>On 4/17/13 at 8:20 AM, observed resident awake and lying in a high winged mattress in her room.</p> <p>An interview was conducted with NA #8 on 4/17/13 at 8:25 AM in regards to the high winged mattress on Resident #69 ' s bed. During the interview, NA #8 reported she was not sure how long the resident had been using this type of bed, but it had been "for a while." When asked about the reason for the high winged mattress, NA #8 stated, " it keeps her from trying to get up." The nurses' aide also indicated it kept the resident from falling. She stated the resident could not get out of bed on her own but she thought the resident would be able to sit up. When NA #8 asked the resident to sit up, the resident said, "I can't " multiple times.</p> <p>During an interview on 4/17/13 at 8:42 AM, QI(quality improvement) Nurse indicated she was responsible for completing assessments for the use of enablers and restraints. Nurse#9 reported Resident #69 had resided on the locked hall from 1/9/12 to 5/29/12. The resident was moved to the 600 Hall when she was noted to have become unsteady and at risk for having more falls. Additional interventions were initiated at that time. The interventions included use of a low bed, mat, and winged mattress. QNurse reviewed her notes</p>	F 221		
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F 221	<p>Continued From page 20</p> <p>during the interview, she reported that on 3/29/12 we " had to restrain her " with a self-release belt. She indicated they tried to get physical therapy involved and tried to use a merri-walker but safety was an issue. Nurse#9 reported that at the time the self-release belt was initiated, Resident #69 was able to release it herself.</p> <p>A follow-up interview was conducted with the QI Nurse on 4/17/13 at 9:10 AM in regards to the use of enablers versus physical restraints. QI Nurse noted Resident #69 's alarmed self-release belt was an enabler (not a restraint). During this interview, she stated that if the resident could release the belt it would be considered an enabler but if the resident couldn't release it then it would be a restraint. The nurse indicated a high winged mattress would be considered a safety intervention and would not be classified as either an enabler or a restraint. QI Nurse indicated that physical restraint evaluations were completed for residents with restraints only (not enablers). A physical restraint evaluation had not been completed for Resident #69 because neither the alarmed seat belt nor the winged mattress was considered a restraint.</p> <p>On 4/17/13 at 10:32 AM the resident was observed to be awake and dressed in her bed. NA #8 and NA #9 were observed as they encouraged the resident to get out of bed on her own. Resident stated, "I can't get up" multiple times. NA #8 assisted the resident to bring her legs over the high wing of the mattress, and then assisted the resident to sit up. With a two-person assist from NA #8 and NA #9, the resident was transferred to her wheelchair and the alarmed seat belt was put into place. The nurses' aides</p>	F 221			

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F 221	<p>Continued From page 21</p> <p>then asked the resident to release the seat belt. Resident #69 was observed trying to release the belt but was unsuccessful. Resident #69 stated multiple times, "I can't."</p> <p>On 4/17/13 at 2:35 PM, an interview was conducted with Restorative Aide #1. The Restorative Aide reported he worked with Resident #69 on transfers and range of motion (ROM) exercises 3-6 times a week. When asked if he thought the resident would be able to get of bed on her own, he replied, "I wouldn't think so."</p> <p>On 4/17/13 at 2:40 PM, observed resident in her wheelchair with the seat belt in place.</p> <p>An interview was conducted with Nurse #7 on 4/17/13 at 4:37 PM. Nurse #7 indicated her understanding of the purpose of the alarming seat belt for Resident #69 and stated the belt was, "to prevent her from falling." Nurse #7 reported that the resident had been able to get the belt off on occasions in the past. The nurse also noted that Resident #69 use to roll out of the bed a lot. However, Nurse #7 stated she had not seen her getout of the high winged mattress. When asked whether the resident would be able to understand that she needed to ring the call bell for assistance, Nurse #7 stated, "I don ' t know if she would really do that now ...she would holler."</p> <p>On 4/18/13 at 8:40 AM observed Resident #69 asleep in her bed with the high winged mattress.</p> <p>An interview was conducted with Nurse #8 on 4/18/13 at 8:59 AM. When asked what the winged mattress enabled the resident to do, the nurse stated, " from her getting out of bed and</p>	F 221			

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F 221	<p>Continued From page 22 falling."</p> <p>On 4/18/13 at 9:40 AM observed Resident #69 asleep in her bed with the high winged mattress.</p> <p>On 4/18/13 at 10:00 AM observed Resident #69 asleep in her bed with the high winged mattress.</p> <p>An interview was conducted with the Director of Nursing (DON) on 4/18/13 at 10:30 AM. When asked what Resident #69 's alarming seat belt was doing to help her, the DON explained, "She was getting up (out of the wheelchair) to get to the bed and having some falls. It is a reminder to her and alerts us to help her."</p> <p>An interview was conducted with the facility's Administrator on 4/18/13 at 10:43 AM. During the interview, the Administrator indicated the high wing bed was put into place for Resident #69 as she believed the resident was able to get out of the lower winged bed.</p> <p>On 4/18/13 at 11:48 AM, observed Resident #69 awake in her bed with the high winged mattress.</p> <p>An interview was conducted with the Nurse#9 on 4/18/13 at 11:56 AM regarding Resident #69. During the interview, the nurse stated, "I look at both the belt and wing mattress as safety interventions." Nurse#9 did not identify any medical condition or clinical symptoms as the reason for use of either the belt or winged mattress. Nurse#9 indicated the alarming seat belt was documented as an enabler while the winged mattress was not. When asked what the alarming seat belt enabled the resident to do, the Nurse #9 responded, "safe seating posture " she</p>	F 221			

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F 221	Continued From page 23 also noted the alarming seat belt enabled her and encouraged her not to rise without assistance with unsafe and unsteady movements and it encouraged her to wait for assistance before transferring. In reference to use of the winged mattress, Nurse#9 indicated this was an intervention put in place following a fall and was documented as an intervention on the Care Plan. When asked what the winged mattress enabled the resident to do, Nurse#9 stated that the mattress "defines parameters " in the bed.	F 221			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain, replace or repair 35 of 128 over bed tables. The findings included: During an observation on 4/17/13 at 8:30 AM, an over bed table was observed in room 135 b to have missing laminate on the table top, the edging of the table was peeled away from the top of the table and a metal rectangular metal piece was sitting on the top of the table. A curled piece of metal was sticking out from the bottom of the table base. An aide was observed coming into the room and placing breakfast on the over bed table.	F 253	F253 Over bed tables in rooms 112B, 133B & 135B were all removed and replaced by the Maintenance Department on 4/17/2013. All facility over bed tables were examined on 5/3/2013 by Maintenance Assistant to check for the need of repair or replacement with corrections conducted as needed. All over bed tables will be monitored for needed repair on a weekly basis per the Maintenance Department utilizing a QI tool. The Maintenance Director will remove, replace, and/or repair the over bed tables upon identification of any concern, Additionally rounds will be performed by administrative staff on daily rounds Monday through Friday and by administrative on	5/17/13	

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F 253	<p>Continued From page 24</p> <p>During an interview on 4/17/13 at 8:57AM, Aide #3 stated that furniture that was in disrepair was reported to the maintenance department. A slip would be turned in and the furniture would be replaced or fixed.</p> <p>During an interview on 4/17/13 at 9:19AM, Aide #4 indicated furniture that wasn't in good repair would be reported to maintenance. She gave the example of an over bed table from room 112 b, whose wheel had fallen off yesterday. She indicated the most problems with furniture were the over bed tables, wheels falling off and the latches to adjust the table was not working.</p> <p>During an interview on 4/17/13 at 10:32AM, Housekeeper #1 indicated she reported broken furniture to the housekeeping supervisor. A maintenance form at the nursing station was also completed.</p> <p>During an interview on 4/17/13 at 10:37AM, Aide #4 observed the bed side table in room 135 b and indicated she would not report the over bed table for repair of the missing laminate. When asked about the metal rectangle sitting on top of the table, she attempted to replace it over the curved piece of metal at the base. She indicated it was the handle that raised and lowered the table. She replaced the handle and the table. The table would not move up or down. As she attempted to move it, the top of the table tilted down and a full cup of coffee spilled onto the floor. She indicated no one noticed the broken table because the resident never needed the height of the table changed.</p> <p>During an observation on 4/17/13 at 10:58AM,</p>	F 253	<p>call on Saturday and Sunday of over bed tables utilizing a QI tool. Any identified concerns during rounds will be forwarded to the Maintenance Department via the use of a work order. Work orders will be checked per the Maintenance Department on an hourly basis throughout the day to ensure repairs are handled timely. If a potential hazard is noted during rounds- the Maintenance Department will be notified through work order process for correction of the furniture and furniture will be removed from environment.</p> <p>Retraining was conducted by Staff Facilitator with all staff regarding observation of the interior, to include overbed tables, monitoring for sanitation, order & hazards. Additionally retraining included the process of work order completion when issues were identified. Retraining completed on 5/14/2013. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p>	

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F 253	Continued From page 25 Maintenance Assistant #1 indicated the over bed table in room 135 b should have been reported for replacement. During an observation on 4/17/13 at 11:04 AM, the Director of Nursing indicated the over bed table 135b, was a hazard to the resident and she removed it from the room . She indicated she expected staff to turn in a slip to the maintenance department. Upon leaving the room Housekeeper #1 indicated she had found another over bed table that needed replacement in room 133 b. Observation revealed the laminate on the table top was peeled away and missing from the edges. During a tour with Maintenance Assistant #1 on 4/17/13 at 11:10 AM, twenty-three bedside table tops were observed to be missing laminate, five required tightening or adjustments. One bed side table was bent; six were missing knobs to adjust the height of the tables. During an interview on 4/17/13 at 12:25 pm, the maintenance supervisor indicated new over bed tables were in the shop ready to go out. He indicated rounds were made daily to look for broken furniture. He expected the aides to tell the maintenance department when equipment doesn ' t work, by filling out the slip at the nursing station. The slips are picked up hourly. The administrator received a copy of the slip once the work was completed. He stated he checked behind the Maintenance Assistant to ensure the work was completed. He indicated there was no set maintenance schedule for over bed tables.	F 253	Audits will be performed on a weekly basis utilizing a QI tool by the Maintenance Department for any identified issues with over bed tables with corrections completed as needed. These audits will be turned into the Administrator weekly for review. Any concerns will be addressed at that time by Maintenance Supervisor. The Executive QI Committee will review audits weekly x 4, monthly x 2 and on a Quarterly basis x 3 for follow up as deemed appropriate and to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time Maintenance Department.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278			

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F 278	<p>Continued From page 26</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately to reflect the use of an alarming seat belt and high winged mattress for 1 of 6 sampled residents reviewed for physical restraints.</p>	F 278	<p>F278</p> <p>Resident #69 was re-assessed for the use of restraints to include alarming self release seat belt & high wings mattress by QI nurse on 4/22/2013 with reflection of the same coded accurately on the MDS.</p> <p>All residents requiring the use of physical restraints had their MDS reviewed and updated as needed by MDS Coordinator on 5/17/2013 for accuracy to ensure correct documentation/ coding of same. All residents requiring newly added device or change to their current restraint device will be addressed with reflection of same on the MDS by 5/17/2013.</p> <p>Audits will be performed on a monthly basis to include Resident #69 by DON utilizing a QI tool to ensure any resident requiring restraint usage has the same reflected on the MDS. Any concerns during observations will be addressed at that time with corrections made as needed MDS Nurse.</p> <p>Retraining conducted by Administrator with MDS nurses regarding accurately coding of the MDS, to include restraint usage, with completion on 5/7/2013. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p>	5/17/13

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F 278	<p>Continued From page 27</p> <p>The findings included:</p> <p>Resident #69 was admitted to the facility on 12/15/11 with cumulative diagnoses including Alzheimer ' s disease, unspecified debility, muscle weakness (generalized), and personal history of falls.</p> <p>A review of Resident #69 ' s medical record revealed February 2013 ' s Monthly Physician Orders included the following Safety Device Order (not dated): " To be in wheelchair with alarming self-release belt applied when out of bed to be used as an enabler to aide with safe sitting posture. "</p> <p>The medical record for Resident #69 also included a Care Plan-General Note dated 3/8/13 which read: " Observed resident leaning forward, attempting to rise without assistance with unsafe movements. Will continue to utilize alarming self release belt to wheelchair as an enabler to aide with safe sitting posture. Wheelchair with alarming self release belt most appropriate and least restrictive device. MD (Medical Doctor) and RP (Responsible Party) made aware. " There was no documentation the resident was able to release the belt.</p> <p>Resident #69 ' s most recent Minimum Data Set (MDS) assessment 3/13/13 revealed the resident required extensive assistance with most Activities of Daily Living (ADLs), including bed mobility, transfers, toileting and personal hygiene. The MDS also indicated physical restraints were not used for this resident while in the bed or in a chair / out of bed. Section P of the MDS defines physical restraints as any manual method or</p>	F 278	<p>Audits will be turned into the Administrator monthly for review. Any concerns will be addressed at that time by DON. The Executive QI Committee will review audits monthly x 4 and on a Quarterly basis x 3 for follow up as necessary and to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.</p>	

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F 278	<p>Continued From page 28</p> <p>physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body.</p> <p>Resident #69 ' s care plan dated 3/25/13 included interventions addressing her risk for falls: 1) " To be in Wheelchair with Alarming Self Release Belt applied when out of bed, to be used as an enabler to aide with safe sitting posture " initiated on 3/29/12 and revised on 4/17/13; and 2) " High Winged Mattress to low bed " initiated on 4/5/12 and revised on 12/17/12.</p> <p>On 4/16/13 at 2:20 PM Resident #69 was observed sitting in her wheelchair with an alarming seat belt in place. During an interview conducted with NA #6 at that time, the nurses ' aide stated the seat belt was an " enabler " and intended to keep the resident safe. When NA #6 asked the resident to remove the belt, she stated, " I can ' t do it " multiple times. Resident #69 was not able to release the seat belt upon request.</p> <p>An interview was conducted with NA #8 on 4/17/13 at 8:25 AM in regards to the high winged mattress on Resident #69 ' s bed. During the interview, NA #8 reported she was not sure how long the resident had been using this type of bed, but it had been " for a while. " When asked about the reason for the high winged mattress, NA #8 stated, " It keeps her from trying to get up. " The nurses ' aide also indicated it kept the resident from falling. She stated the resident could not get out of bed on her own but she thought the resident would be able to sit up. When NA #8 asked the resident to sit up, the</p>	F 278			

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F 278	<p>Continued From page 29</p> <p>resident said, "I can ' t " multiple times.</p> <p>During an interview on 4/17/13 at 8:42 AM, the Quality Improvement (QI) Nurse indicated she was responsible for completing assessments for the use of enablers and restraints. The QI Nurse reported Resident #69 had resided on the locked 500 Hall from 1/9/12 to 5/29/12. The resident was moved to the 600 Hall when she was noted to have become unsteady and at risk for having more falls. Additional interventions were initiated at that time. The interventions included use of a low bed, mat, and winged mattress. As the QI Nurse reviewed her notes during the interview, she reported that on 3/29/12 " we had to restrain her " with a self-release belt. She indicated they tried to get Physical Therapy (PT) involved and tried to use a merri-walker but safety was an issue. The QI Nurse reported that at the time the self-release belt was initiated, Resident #69 was able to release it herself.</p> <p>A follow-up interview was conducted with the QI Nurse on 4/17/13 at 9:10 AM in regards to the use of enablers versus physical restraints. The QI Nurse noted Resident #69 ' s alarmed self-release belt was an enabler (not a restraint). During this interview, she stated that if the resident could release the belt it would be considered an enabler but if the resident couldn't release it then it would be a restraint. The nurse indicated a high winged mattress would be considered a safety intervention and would not be classified as either an enabler or a restraint. The QI Nurse indicated that physical restraint evaluations were completed for residents with restraints only (not enablers). A physical restraint evaluation had not been completed for Resident</p>	F 278			

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F 278	<p>Continued From page 30</p> <p>#69 because neither the alarmed seat belt nor the winged mattress was considered a restraint.</p> <p>On 4/17/13 at 10:32 AM the resident was observed to be awake and dressed in her bed. NA #8 and NA #9 were observed as they encouraged the resident to get out of bed on her own. Resident stated, " I can ' t get up " multiple times. NA #8 assisted the resident to bring her legs over the high wing of the mattress, and then assisted the resident to sit up. With a two-person assist from NA #8 and NA #9, the resident was transferred to her wheelchair and the alarmed seat belt was put into place. The nurses ' aides then asked the resident to release the seat belt. Resident #69 was observed trying to release the belt but was unsuccessful. Resident #69 stated multiple times, " I can ' t. "</p> <p>An interview was conducted with the QI Nurse on 4/18/13 at 11:56 AM regarding Resident #69. During the interview, the nurse stated, " I look at both the belt and wing mattress as safety interventions. " No medical condition or clinical symptoms were identified as the reason for use of either the belt or winged mattress. The QI Nurse indicated the alarming seat belt was documented as an enabler while the winged mattress was not. When asked what the alarming seat belt enabled the resident to do, the QI Nurse responded, " Safe seating posture. " She also noted the alarming seat belt enabled her and encouraged her not to rise without assistance with unsafe and unsteady movements and it encouraged her to wait for assistance before transferring. In reference to use of the winged mattress, the QI Nurse indicated this was an intervention put in place following a fall and was</p>	F 278			

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F 278	Continued From page 31 documented as an intervention on the Care Plan. When asked what the winged mattress enabled the resident to do, the QI Nurse stated that the mattress " defines parameters " in the bed. An interview was conducted with Nurse #12 on 4/18/13 at 12:26 PM. Nurse #12 reported that she shared responsibility for working with the MDS assessments. Nurse #12 indicated that the QI Nurse was responsible for providing input on assessments for safety precautions and resident interventions. Nurse #12 reported that falls, referrals to therapy, and interventions were discussed in a Medicare meeting held every weekday morning. The nurse also indicated that " a lot of times " the QI Nurse would go into residents ' care plans and update interventions put into place. The QI Nurse would then communicate assessment and care plan revisions to the nurses working with the MDS assessments and care plans.	F 278			
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	F 279	F279 The Care Plan was updated on 4/22/2013 by MDS Nurse to reflect the individualized care needs, to include dialysis, for Resident #156. Care Plans and Care Guides for all residents receiving dialysis care were updated by MDS nurse on 4/25/2013 to reflect needs related to dialysis.	5/17/13	

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F 279	<p>Continued From page 32</p> <p>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 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews the facility failed to develop a comprehensive care plan to address the needs for 1 of 6 residents requiring dialysis(Resident #156). Findings include:</p> <p>Resident #156 was admitted on 2/1/13, with the diagnoses of anemia, diabetes mellitus, end stage renal disease, and hemiplegia.</p> <p>The most current Minimum Data Set (MDS) dated 2/18/13, indicted he had long and short term memory loss and required dialysis treatments.</p> <p>Review of his current care plans with various dates, did not address Residents #156 dialysis treatments and care of access shunt.</p> <p>Review of the care guide with no date, did not indicate special care directions for a dialysis resident.</p> <p>During an interview on 4/19/13 at 3:29PM, Aide # 1 indicated she had cared for Resident # 156 the previous day. She was unable to verbalize if resident had a fluid restriction, type of diet or type of access. When asked how she would learn that</p>	F 279	<p>All residents receiving specialized care to include dialysis will be assessed per the MDS Coordinator upon admission, quarterly, annually, and upon any changes throughout their stay to ensure the Care Plan and Care Guide reflect care needs accurately.</p> <p>Audits will be performed utilizing a QI tool on a monthly basis by DON to ensure any resident to include Resident #156 requiring dialysis has the same reflected on their Care Plan and Care Guide. Any concerns during observations will be addressed at that time with corrections made as needed MDS Nurse.</p> <p>Retraining conducted by Staff Facilitator with all staff regarding on where to find specific care needs of a resident, to include those on dialysis, on the Care Plan and Care Guide with completion on 5/14/2013. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p>	

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F 279	<p>Continued From page 33</p> <p>information she indicated she would look at the care guide.</p> <p>During an interview on 4/19/13 at 3:35PM, Nurse #1 indicated care plans are not done for dialysis patients, because care was incorporated by everyone. Dialysis information was documented in a flow sheet on the computer, by the nurse. Nurse #1 indicated the aides refer to the care guide in the closet. There was no written care plan.</p> <p>During an interview on 4/19/13 at 3:45PM, Aide #2 indicated she had just received resident #156 from another hall. She indicated she did not know where Resident #156 had shunt access for dialysis treatments. She indicated she would look at the care guide to care for him.</p> <p>During an interview on 4/19/13 at 4:00PM, Resident #156 indicated he had a dialysis shunt in his left arm. He went to dialysis three days a week. He could not have blood pressures taken in his left arm.</p> <p>During an interview on 4/19/13 at 4:05 PM, the Administrator indicated the expectation was the MDS nurse would create the dialysis care plan. This was transcribed to the resident care guide to communicate to the aide, the care a dialysis shunt, fluid restriction and diet.</p> <p>During an interview on 4/19/13 at 5:15PM, the MDS nurse indicated dialysis should be care planned and transcribed to the care guide by the Assistant Director of Nurses (ADON).</p>	F 279	<p>Audits will be turned into the Administrator monthly for review. Any concerns will be addressed at that time by DON. The Executive QI Committee will review audits monthly x 4 and on a Quarterly basis x 3 for follow up as demed necessary, and to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time by DON.</p>		

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F 279	<p>Continued From page 35</p> <p>deit as order fluid restrict as order (per dialysis resident may have ice chips monitor lab per order monitor resident for sign of dehyd ovserved residnet for signs of pain vital signs as orderd or per facility protocol weights per facility protocol</p> <p>Care plan state of nourishment less than body requirement characterized by weight loss inadeqate intake decreased appetite related to being on therapeutic diet illness Leaves 25% or more food uneatien at most meals presence of pressure ulcers veing on mechanically altered dietr G 5/19/13 will not experience sig wt loss</p> <p>Nichole Jones 329 On 4/19/13 had him yesterday, he still urinates, able to make need known , doesnt know if he is on fluid restriction, doesnt know what kind of access he has , doesnt know type diet. i would look at his chart in his closet for his care. moved to room 308</p> <p>resident in his room just returning from diaysis 332pm 4/19/13</p> <p>Susan Talley 335 pm 4/19/13 in the computer there is a section for the diaysis patient a drop down box is addressed. which address all areas and communications address, access, mental status, general condition, shunt site, times he return, any instruction from dialysis, and when the dressing is removed.</p>	F 279		

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F 279	<p>Continued From page 36</p> <p>he is on a fluid restriction it is on his mar and in the md orders.</p> <p>he is on a 1600 fluid restriction. most of the time they do not get a water pitcher. most of the time . they will get about 70 cc of water with medication. he is on a special renal diet.with double meats. no care plan because the care is incorporated into everybody.</p> <p>aide are told by the nurse there is a dietary slip on the tray , care plan in the closet. She indicated there was no written careplan.</p> <p>Carolyn Fogg cna t345pm 4/19/13</p> <p>i just got him from his previous hall today. he get water, mighty shake and apple juice on his tray. I do not know what kind of access he has. His daughter has brought him in a cup that is kept by his bedside.</p> <p>During an interview on 4/19/13 4:00 pm Resident indicated he has a left forearm left arm access, indicated he is on a fluid restrict, special diet.</p> <p>Shannon Knight administrator 405 pm 4/19/13 resident care guide, it should indicted the fluid restriction , or the diet, that would be addressed. water pitcher must have a waiver, The guide should have indicate the dialysis shunt is protected., The mds should have created a careplan for dialysis and the nursing staff would updated.</p> <p>Norma Sizemore RN SDC 503pm on 4/19/13, a care plan should be written on diaysis patient, the care would specify what care , ie, no stick or bp in</p>	F 279		

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F 279	Continued From page 37 the arm with access, and basic care, and special, diet and fluid restrictions. Lisa Thorton RN 515pm 4/19/13, work in MDS as the coordinators, we do assessment and careplans, the care guides are done by the adon and the and as changes are done they are implemented on the care guide. Dialysis should be careplanned. it isnt specifically triggered. the care plan would address fluid restriction , dressing shunt, days of diaysis. All orders, are used to create the care plan to keep from missing anything., reviewed current careplan indicated the dietary department had address the fluid restriction. she indicated she didnt see a care plan for diaylsis. how do you communicate with diaysis , the phebotomist Kayla Inman LPN communicates with the dialysis facility.	F 279			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed provide restorative ambulation and active range of motion as recommended by physical therapy department	F 318	F318 Resident #117 was re-assessed for the continued need for restorative nursing therapy by Restorative Nurse on 5/7/2013 with reflection of the same documented on the Care Plan. All residents receiving restorative nursing therapy were assessed for the continued need for restorative therapy by Restorative Nurse on 5/8/2013 with changes made as needed to their individualized plan of care.	5/17/13	

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F 318	<p>Continued From page 38</p> <p>and identified in care plan for 1 of 4 residents in the restorative program (Resident #117). The findings included:</p> <p>Resident #117 was admitted to the facility on 4/8/201, Resident #117 cumulative diagnoses included hypertension, coronary artery disease, failure to thrive, mental disorder, dementia and general muscle weakness. The annual Minimum Data Set (MDS) dated 10/4/12, indicated that Resident #117 had severe short and long term memory and decision making problems. The MDS also indicated that Resident #117 needed assistance with all activities of daily living, transfers and ambulation. Resident #117 did not exhibit any behaviors during the assessment period. Resident #117 required two person assistance and the use of a lift. Review of the falls risk assessment dated 9/28/11 to current revealed that Resident #117 did not have any falls.</p> <p>Review of the restorative ambulation program dated 4/27/12, revealed Resident #117 would ambulate 3-6 times a week with rolling walker and a one person assistance. The active range of motion program included AROM(active range of motion) group 3-6 times a week with exercise for at least 15minutes or more.</p> <p>Review of the care plan dated 10/4/12, identified Resident #117 needed assistance/potential to restore or maintain maxium function of self sufficiency for mobility characterized by the following functions: positioning, locomotion, ambulation related to at risk for decline in ability to ambulate and range of motion in upper/lower extremities. The goals included the resident</p>	F 318	<p>Audits will be performed utilizing a QI tool on a weekly basis by the Restorative Nurse to include Resident #117 to ensure compliance with the plan of care for each individual resident observed. Any concerns during observations will be addressed at that time with corrections made as needed by Restorative Nurse.</p> <p>Retraining conducted by Administrator with all restorative care aides on providing restorative therapy per the individualized plan of care written out for each resident with completion on 5/8/2013. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p> <p>Audits will be turned into the Administrator weekly for review. Any concerns will be addressed at that time by Restorative Nurse. The Executive QI Committee will review audits weekly x 4, monthly x2 and on a Quarterly basis x 3 to follow up on identified concerns as a appropriate, and determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time by Restorative Nurse.</p>		

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F 318	<p>Continued From page 39</p> <p>would walk 150 feet or more with rolling walker and one person assistance. Interventions included 3-6 times a week walk for 100ft or more with rolling walker, if resident did not participate in restorative ambulation program document reason. Resident #117 would not have any limitations of range of motion in upper/lower extremities by next review. Interventions included active range of motion 3-6 times week and/or exercise for at least 15 minutes or more and document if resident did not participate in restorative group activities.</p> <p>Review of the restorative nursing ambulation program documented January 2013 that the program was done 9 times out of 31 days, February 4 times of 28 days, March 8 times of 31 days and April 4 times from 4/1/13-4/19/13. The time indicated for the ambulation program averaged from 6 to 13 minutes. Additional, review of the AROM program, Resident #117 received 9 days in January, 11 days in February, 14 days March and 5 days in April. The average time provided for the AROM ranged from 5 to 10 minutes. The care plan identified 15 minutes or more. There were no observations of staff ambulating or providing range of motion for Resident #117 for five days during survey and Resident #117 was observed throughout the day located in designated area at nurses station.</p> <p>Review of the restorative summary dated 1/3/13 through 4/19/13, did not document anything related to the restorative ambulation program evaluation and/or progress. There were no notes to indicate that Resident #117 had been doing ambulation or that it was refused. The notes addressed restorative dining program.</p>	F 318			

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F 318	<p>Continued From page 40</p> <p>Review of the general note dated 2/20/13, revealed that Resident #117 was re-assessed for transfers, standing/ambulation, lifts and the need for a two person assistance.</p> <p>Review of the social worker (SW) #2 notes dated 4/11/13, revealed the care plan meeting was held and the following concerns were addressed with the responsible person, medications, restorative dining, ambulation/exercise, active range of motion 3-6 times per week, falls risk and on-going medical conditions.</p> <p>During an observation on 4/16/13 at 10:47AM, Resident #117 was seated at nursing station in wheelchair with chair slightly reclined back with posey belt restraint in place around her waist and tied to back of chair. There were no repetitive movements in any directions. Resident#117 was very quiet/calm and staring into space.</p> <p>During an observation on 4/16/13 at 3:00PM, Resident#117 was seated on the hall at the nursing station sleep with posey belt restraint tied around her waist and to the back of the chair and the chair reclined back. Resident #117 was awakened by noise and was very confused and unable to comprehend the conversation or the use of the restraint. There were no repetitive movements in any direction</p> <p>During an observation on 4/17/13 at 8:37AM, Resident#117 chair was slightly reclined back and she was seated in the dining room eating her breakfast in restorative feeding self with posey belt tied to around her waist and to the back of the chair. She required cueing to get started with</p>	F 318			

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F 318	<p>Continued From page 41</p> <p>her meal from the restorative aide.</p> <p>During a follow-up interview RA#1 on 4/18/13 at 8:30AM, indicated that they have no scheduled time to perform the ROM and/or ambulation program and RA get to each resident when they could and sometimes they didn ' t get to them in the amount of time in accordance to the program listed in the system. The program for ambulation and range of motion was for 3-6wk, they have not been consistent due to limited staff and other responsibilities.</p> <p>During an interview on 4/17/13 at 8:57AM, Nurse #3 indicated that Resident #117 the alarm was added to alert the staff of when the Resident#117 attempted to get up, but she generally was stationary in the chair. She does not have any repetitive movements or behaviors. He added that it was an enabler to prevent falls.</p> <p>During an interview on 4/17/13 at 9:09AM, Nurse#11indicated she was responsible for assessing the restraints and indicated that the posey belt was a restraint. Resident#117 leaned forward and on right side, to pick up things off the floor. Nurse##11 stated that her leaning over was unsafe. Resident#117 would also grab onto the handrails gets to hand rail attempts to scoot or pulled herself up down the hall. Resident#117 had the restraint on mainly due to her leaning and there was no medical reason for the use of the restraint. She added that she had it for a long time and there had been no change. Resident#117 did not have any repetitive behaviors. She added that there were no other</p>	F 318			

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F 318	<p>Continued From page 42</p> <p>devices attempted other than to apply the position pillow. Review of the restraint evaluation revealed per Nurse# that there was no alternative device attempted to eliminate and/or reduce the use of the restraint. Resident #117 had not been assessed by therapy nor was there other interventions applied or tried. Resident #117 was involved in the restorative ambulation program.</p> <p>During an observation on 4/17/13 at 9:41AM, Resident#117 was seated at the nursing station restraint sleep in wheelchair with posey belt around waist and tied to back of the reclined chair.</p> <p>During an interview on 4/17/13 at 9:46AM, physical therapy manager(PTM) indicated that Nurse#11 was responsible for doing the assessment for restraints. PTM indicated there was no current restraint reduction program. The therapy department did not routine screen or evaluate residents for restraints unless they were currently been seen by the department staff. The nursing department handled the assessment, evaluation and determination for the use of restraints and she was unaware of the specific process currently being used to assess and determine which residents would need restraints. Therapy was responsible for assessments referred due to falls or other mobility/transfer changes.</p> <p>During observation an interview on 4/17/13 at 12:10PM, Resident#117 observed seated at the nursing station with baby doll in hand and wheelchair slightly reclined backed with posey belt in place. Nurse#9 indicated that she was responsible for assessing and monitoring the</p>	F 318			

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F 318	<p>Continued From page 43</p> <p>restorative program. She added that the Resident #117 was involved in the restorative ambulation program/range of motion program to improve and maintain her ambulation and active range of motion skills 3-6 times a week. She further stated that there was no scheduled times for this program to be implemented and that when the resident refuse it should be documented. Nurse #9 indicated that she was responsible for monitoring the program to ensure that residents were receiving the ambulation, but she did not have a system in place to ensure this was being done. She also added that there was no doctor order for when the restorative program. The program was set up by the previous coordinator for all residents on ambulation to be walked 3-6 times a week and/or on a range of motion program.</p> <p>Nurse#9 reviewed Resident #117 current ambulation and range of motion program and acknowledged that Resident#117 restorative program and care plan had not been consistently been done. In addition, she acknowledged she did not have documentation to indicate whether Resident#117 had actually received the service or whether progress was noted.</p> <p>During an interview on 4/17/13 at 4:50PM, NA#10 indicated that Resident#117 did not have any other behaviors and that ambulation was suppose to be done on 1st shift through the restorative program.</p> <p>During an interview on 4/18/13 at 12:35PM, PT#2 indicated that once the resident was referred to restorative, he would periodically checks with Nurse#9 to see how the residents</p>	F 318		

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F 318	Continued From page 44 was doing with the recommended program. He indicated that he did not have any documentation of the discussion and he did not follow-up on the progress or not.	F 318			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to prevent access to hand sanitizer for 1 of 1 sampled residents (Resident #69) with a history of previous attempts to take items off of nursing medication carts. The findings included: Resident #69 was re-admitted to the facility on 1/21/13 with cumulative diagnoses including diabetes, Alzheimer 's Disease, dementia and anxiety. The most recent quarterly Minimum Data Set (MDS) dated 3/13/13 indicated the resident had moderately impaired cognitive skills for daily decision making. Wandering behaviors and physical behavior symptoms not directed toward others were noted to occur on a daily basis. The MDS also revealed Resident #69 required extensive assistance with bed mobility and transfers. She was noted as having the	F 323	F323 Physical assessment of Resident #69 was completed on 4/16/13 by RN Supervisor with no abnormal findings. She was further monitored per the recommendations of the Poison Control Center and MD. Additionally, Resident #69 was moved to the Alzheimer's Unit due to her continued wandering and rummaging behaviors. Hand Sanitizer was removed from all medication carts on 4/19/2013 to prevent recurrence of the same concern. Audits utilizing a QI tool were performed twice a shift x 2 weeks with no issues noted, then changed to once a shift. Audits will continue to be performed on an every shift basis by Administrative Nurses to ensure compliance by nursing staff. Any concerns during observations will be addressed at that time with corrections made as needed by Administrative Nurses.	5/17/13	

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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27026		
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F 323	<p>Continued From page 45</p> <p>ability to independently propel herself in the wheelchair throughout the facility.</p> <p>A review of Resident #69 's medical record revealed a " Behavior " notation was made in the progress notes on 3/20/13: "Resident has tried to take items from nursing cart. All eatable items (were) removed for her safety. Afterwards she wanders away."</p> <p>Resident #69 's care plan dated 3/25/13 included a problem for trauma potential related to wandering. The goal for the resident was noted as: Whereabouts to be known to staff as demonstrated by no evidence of leaving the facility unsupervised. Interventions included: Check for whereabouts frequently, involve in activities as appropriate, and orient to surroundings and room number as frequently as needed.</p> <p>A review of an incident report dated 4/16/13 at 3:25 PM, revealed Resident #69 was seen by the facility's nursing staff to take a bottle of [brand name] hand sanitizer from the medication cart and drink an undetermined amount from it. Resident was given water to drink and the Poison Control Center was contacted. The Poison Control Center recommended the resident be given food and drink, have her blood glucose (sugar) checked, and be monitored for any changes in level of consciousness. The Poison Control Center indicated that Resident #69 could possibly experience gastrointestinal upset from ingestion of the hand sanitizer. Further review of the incident report revealed resident remained alert and conversant with no complaints of nausea. Blood glucose results = 112 mg/dl</p>	F 323	<p>Retraining conducted by Staff Facilitator with all staff on keeping hand sanitizer off of medication carts at all times with completion on 5/9/2013. Retraining included ensuring hand sanitizer was maintained/ stored out of the resident's reach. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p> <p>Audits will be turned into the Administrator daily for review. Any concerns will be addressed at that time Administrator. The Executive QI Committee will review audits weekly x 4, monthly x2 and on a Quarterly basis x 3 for any identified concerns, and to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.</p>		

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F 323	<p>Continued From page 46 (normal range = 80-120 mg/dl). The incident report noted staff education was provided to keep the hand sanitizer out of the residen 's reach.</p> <p>A review of the in-service training report dated 4/18/13 revealed the subject(s) covered as: " Hand sanitizer must be stored out of the reach of residents. Not on top of medication or treatment carts. If stored on medication cart MUST BE STORED SEPARATELY FROM INTERNALS. " As of 4/19/13, 20 of the 35 staff nurses and 10 of the 22 staff nursing assistants/medication aides had received in-service education on this topic.</p> <p>An interview was conducted with Nurse #5 on 4/19/13 at 10:21 AM, Nurse #5 stated that she was not working at the time of the 4/16/13 incident when Resident #69 ingested the hand sanitizer. However, Nurse #5 indicated she was aware that Resident #69 would get nutritional supplements, applesauce and cups off of the medication cart. To discourage this behavior, staff would put a sheet over the cart or try to store the medication cart in the locked medication room when not in use. When asked how often these behaviors occurred with Resident #69, the nurse reported the resident would be " messing with things on the med cart " at least daily.</p> <p>An interview was conducted with Nurses Aide (NA) #6 on 4/19/13 at 11:15 AM. NA #6 had been present at the time of the 4/16/13 incident when Resident #69 ingested the hand sanitizer. NA #6 stated she was in the nursing station with the Hall nurse and two other nurses ' aides when the resident was observed drinking the hand sanitizer from the medication cart. The NA reported that prior to this incident on 4/16/13, she had "</p>	F 323		

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F 323	<p>Continued From page 47</p> <p>sometimes " seen the resident grab items off of the medication cart.</p> <p>An interview was conducted with the Director of Nursing (DON) on 4/19/13 at 11:25 AM, in regards to the incident report dated 4/16/13. The DON reported that Nurses and Medication Aides have been in-serviced on storing hand sanitizer gels out of reach of the residents. The DON indicated she had not been aware that Resident #69 had made previous attempts to take items from the top of the medication cart. The DON stated she would have expected nurses and nurses ' aides to let her know of such behaviors so appropriate interventions may have been put into place.</p> <p>On 4/19/13 at 1:50 PM, observed the 400 Hall medication cart had a bottle of hand sanitizer placed on it. The 400 Hall medication cart was parked outside of the nurses ' station and not in use at the time.</p> <p>On 4/19/13 2:11 PM observed the 400 Hall medication cart parked outside of the nurses ' station and not in use at the time. The bottle of hand sanitizer was on the cart. Observed the Administrator of the facility notice the hand sanitizer and remove it from the cart.</p> <p>An interview was conducted with the Social Worker (SW) on 4/19/13 at 2:24 PM in regards to Resident #69 's behaviors. During the interview, the SW reported that she had not witnessed Resident #69 trying to reach for items off of the medication carts.</p> <p>An interview was conducted on 4/19/13 at</p>	F 323		

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F 323	Continued From page 48 2:55PM with NA #7. NA #7 had not been present at the time of the 4/16/13 incident when Resident #69 ingested the hand sanitizer but had worked with the resident in the past. During the interview, NA #7 indicated that the resident did reach for items off of the medication cart "quite a bit of the time." An interview was conducted with Nurse #6 on 4/19/13 at 3:00 PM. Nurse #6 was on duty at the time of the 4/16/13 incident. During the interview, Nurse #6 detailed the incident as it was described in the 4/16/13 Incident Report. When asked whether or not the resident had exhibited similar behaviors in the past, the nurse reported, "she's gotten into stuff." Nurse #6 indicated Resident #69 liked to handle things and had gotten into items kept in the Chart Room on occasions. She also noted that approximately one month ago, Resident #69 went into a man's room and got into his night table drawer. Nurse #6 indicated the staff attempted to keep her within view but she was sometimes hard to keep up with " An interview was conducted with the Administrator on 4/19/13 at 4:00 PM., the Administrator acknowledged that in-service education on storage of hand sanitizer needed to be completed and reinforced. The Administrator stated that she had taken a bottle of hand sanitizer off of the top of a medication cart that afternoon. She indicated her expectation would be for the hand sanitizer to be stored out of reach of the residents.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431			

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F 431	<p>Continued From page 49</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to label medications with an expiration date in 1 of 3 medication rooms</p>	F 431	<p>F431</p> <p>All medication carts and storage areas, including refrigerators and medication rooms, were checked by Resident Care Liaison on 5/8/2013 to ensure all medications were labeled and stored appropriately according to manufacturer recommendations and per policy.</p> <p>All Glucose Test Strips, Insulins, Inhalers, Intranasal Sprays & Nebulizer Solutions are checked on a weekly basis utilizing a QI tool by Resident Care Liaison to ensure continued compliance with labeling and storage recommendations. Any identified concerns will be addressed at that time by the Resident Care Liaison.</p> <p>Retraining was conducted by the DON with all nurses and medication aides on the proper way of labeling and storage of medication on 5/14/2013. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p>	5/17/13	

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F 431	<p>Continued From page 50</p> <p>(200 Hall) and 2 of 8 medication carts (400 and 500 Hall medication carts); and failed to store medications and/or glucose test strips as specified by the drug manufacturer in 1 of 3 medication rooms (200 Hall) and 2 of 8 medication carts (100 and 400 Hall medication carts).</p> <p>Findings included:</p> <p>1) An observation of the 200 Hall medication refrigerator on 4/17/13 at 4:15 PM revealed an open, undated vial of Humalog insulin. The manufacturer's product information indicated, "once punctured (in use), vials may be stored under refrigeration or at room temperature; use within 28 days."</p> <p>During an interview with Nurse #2 on 4/17/13 at 4:15 PM, the nurse indicated the opened vial should have been labeled with the date it had been opened. Nurse #2 indicated this vial of insulin would be discarded and a new vial obtained for the resident. Nurse #2 stated that once opened and dated, the insulin would be good for 28 days.</p> <p>During an interview with the Director of Nursing (DON) on 4/18/13 at 10:30 AM, the DON addressed the normal procedure for storing opened injectable medications such as Humalog insulin. The DON indicated that when a nurse opened a vial of insulin, it should be dated. The DON also indicated any insulin that was not dated should be thrown away and a new vial opened. She noted that opened vials of insulin would usually be kept for 28 days or whatever the manufacturer called for.</p>	F 431	<p>Audits will be turned into the Administrator weekly for review. Any concerns will be addressed at that time by Resident Care Liaison. The Executive QI Committee will review audits weekly x 4, monthly x2 and on a Quarterly basis x 3 to address any identified concerns and to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time by Resident Care Liaison.</p>		

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F 431	<p>Continued From page 51</p> <p>2) An observation of the 500 Hall medication cart on 4/18/13 at 8:27 AM, revealed an Asmanex Twisthaler 220 mcg/actuation (a dry powder inhaler used for asthma) with a counter reading of "09" was not dated as to when it had been removed from the foil pouch. Supplemental labeling from the dispensing pharmacy for the inhaler noted the Twisthaler should be discarded 45 days after opening the foil pouch or when the dose counter reached "00", whichever comes first. Manufacturer product labeling indicated the Asmanex Twisthaler device should be discarded when the oral dose counter reads "00" or 45 days after opening the foil pouch, whichever comes first.</p> <p>During an interview with Nurses ' /Medication Aide (NA) #6 on 4/18/13 at 8:27 AM, the Aide indicated an inhaler such as Asmanex Twisthaler needed to be labeled with the date it was removed from the foil pouch.</p> <p>During an interview with the DON (Director of Nursing) on 4/18/13 at 10:30 AM, the DON stated that an Asmanex Twisthaler should be dated when it is removed from the foil pouch. She acknowledged that an Asmanex Twisthaler should be discarded 45 days after opening the foil pouch or when the dose counter reached " 00 " , whichever comes first.</p> <p>3-a) An observation of the 400 Hall medication cart on 4/18/13 at 8:44 AM revealed an open, undated bottle of calcitonin spray 200 mcg/actuation (an intranasal spray used for osteoporosis) in the medication cart drawer. Supplemental labeling from the dispensing pharmacy for the calcitonin spray included, " Expires 30 days after opening " The</p>	F 431			

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F 431	<p>Continued From page 52</p> <p>manufacturer ' s product information indicated an opened product may be stored at room temperature for up to 30 days.</p> <p>During an interview with Nurse #3 on 4/18/13 at 8:44 AM, the nurse indicated the opened bottle should have been labeled with the date it was opened. Nurse #3 stated that once opened and dated, the calcitonin nasal spray may be used for up to 30 days. The nurse indicated he would need to check with the pharmacy to see what needed to be done with this opened bottle of calcitonin nasal spray.</p> <p>During an interview with the Director of Nursing (DON) on 4/18/13 at 10:30 AM, the DON addressed the normal procedure for storing an opened bottle of calcitonin. The DON indicated her expectation would be that when a nurse opened a bottle of calcitonin, it should be dated. She acknowledged that an opened bottle of calcitonin would need to be discarded after 30 days.</p> <p>3-b) An observation of the 400 Hall medication cart on 4/18/13 at 8:44 AM revealed an opened bottle of calcitonin spray 200 mcg/actuation (an intranasal spray used for osteoporosis) lying down on its side in the medication cart drawer. Supplemental labeling from the dispensing pharmacy for the calcitonin spray included, " Keep bottle upright. " The manufacturer ' s product information indicated an opened product should be stored in an upright position.</p> <p>During an interview with Nurse #3 on 4/18/13 at 8:44 AM, the nurse indicated the opened bottle should have been stored in an upright position.</p>	F 431			

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F 431	<p>Continued From page 53</p> <p>The nurse indicated he would need to check with the pharmacy to see what needed to be done with this opened bottle of calcitonin nasal spray.</p> <p>During an interview with the Director of Nursing (DON) on 4/18/13 at 10:30 AM, the DON addressed the normal procedure for storing an opened bottle of calcitonin. The DON indicated her expectation would be that when a nurse opened a bottle of calcitonin, it should be stored upright in the medication cart.</p> <p>4) An observation of the 200 Hall medication refrigerator on 4/17/13 at 4:15 PM revealed an open container of blood glucose (blood sugar) test strips was stored in the refrigerator. There were approximately 30-35 test strips in the open container. The manufacturer ' s product information specifically indicated, " Do not freeze or refrigerate. "</p> <p>During an interview with Nurse #2 on 4/17/13 at 4:15 PM, the nurse stated the opened container of test strips should not have been refrigerated. Nurse #2 indicated this container of test strips needed to be discarded and acknowledged that blood glucose test strips should be stored at room temperature. Nurse #2 disposed of the refrigerated vial of blood glucose strips.</p> <p>During an interview with the Director of Nursing (DON) on 4/18/13 at 10:30 AM, the DON stated she would have expected blood glucose test strips to be stored at room temperature. She indicated the refrigerated container of test strips needed to be discarded.</p> <p>5) An observation of one of the 100 Hall medication carts on 4/18/13 at 9:09 AM revealed 10 vials of ipratropium bromide 0.02% solution (a nebulizer solution used for asthma and COPD)</p>	F 431			

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F 431	Continued From page 54 were stored in the bottom of the medication cart drawer outside of the manufacturer ' s foil pouch. Product labeling on the package of the ipratropium bromide solution indicated, " Protect from light; Store unused vials in the foil pouch. " During an interview with Nurse #4 on 4/18/13 at 9:09 AM, the nurse indicated that the ipratropium bromide solution vials needed to be stored inside the foil pouch in accordance with the manufacturer ' s storage recommendations. During an interview with the Director of Nursing (DON) on 4/18/13 at 10:30 AM, the DON stated that her expectation would be for ipratropium bromide solution vials to be stored inside the foil pouch until used as indicated by the manufacturer ' s product labeling.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F441 Resident #118 received a blood glucose monitoring check on 4/17/13 after disinfecting of the glucometer was completed by Licensed Nurse. She has continued to receive blood glucose monitoring as ordered only after disinfecting of the glucometer per CDC guidelines/ policy. All residents requiring blood glucose monitoring receive checks as ordered upon disinfecting of the glucometer per CDC guidelines/ policy.	5/17/13

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 55</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to clean and disinfect a shared glucometer for 1 of 2 residents observed (Resident #118) receiving blood glucose monitoring.</p> <p>The findings included:</p> <p>The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration. The CDC guidelines have indicated that if glucometers are shared, the device must be cleaned and disinfected between each patient use.</p>	F 441	<p>Audits utilizing a QI tool are performed weekly to ensure compliance by nursing staff in cleaning/ disinfecting of the glucometers, to include between each resident to include Resident #118 and appropriate disinfectant solution for specified time period is performed. Any concerns during observations will be addressed at that time with immediate retraining as needed by ADON.</p> <p>Retraining conducted by ADON with all nurses and medication aides on the proper procedure of disinfecting the glucometer between each resident with completion on 5/14/2013. Any staff member on vacation, leave or PRN will receive retraining prior to returning to work.</p> <p>Audits will be turned into the Administrator weekly for review. Any concerns will be addressed at that time ADON. The Executive QI Committee will review audits weekly x 4, monthly x2 and on a Quarterly basis x 3 to follow up on any potential or identified concerns as needed and to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time by ADON.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/19/2013
NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		
(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 441	<p>Continued From page 56</p> <p>According to the manufacturer ' s care instructions for maintenance of the [brand name] glucometer, the meter may be disinfected using a 1:10 dilution of household bleach (1 part of 5-6% sodium hypochlorite solution to 9 parts of water). The manufacturer guidelines also indicated, " In accordance to CDC guidelines, we recommend that the [brand name] meter be cleaned between resident tests in a multi-resident setting. "</p> <p>Review of the facility's policy on Cleaning and Disinfection of Glucometers dated 3/8/11 stated in part, "If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer ' s directions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal, bloodborne pathogen to include HIV (human immunodeficiency virus), HBV (hepatitis B virus), and HCV (hepatitis C virus) label claim or a dilute bleach solution of 1:10 to 1:100 concentration. "</p> <p>During an observation on 4/17/13 at 12:13PM, Nurse #1 used a [brand name] glucometer to obtain a blood glucose reading for Resident #114. After the reading was taken, the nurse set the glucometer on top of the medication cart. The glucometer was neither cleaned nor disinfected. Nurse #1 was continually observed during the medication administration pass as this glucometer remained on top of the medication cart. At 12:34 PM, Nurse #1 prepared to obtain a blood sample from Resident #118. The nurse gathered the supplies, put on gloves and inserted a test strip into the glucometer which had been previously used for Resident #114 and subsequently stored on top of the medication cart. Nurse #1 knocked on Resident #118 ' s</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27026		
(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 441	<p>Continued From page 57</p> <p>door and began to enter her room. The nurse was requested to step out of the resident ' s room into the hallway and questioned as to whether anything was used to disinfect a shared glucometer between resident tests. Nurse #1 replied, " Oh, yes " and then pulled [brand name] disinfectant wipes from the medication cart and used a wipe to disinfect the shared glucometer prior to completing a blood glucose test for Resident #118. During an interview with the nurse at that time, Nurse #1 indicated she didn ' t know why she had forgotten to disinfect the shared glucometer between resident tests as she knew she needed to do so.</p> <p>An interview on 4/18/13 at 10:30 AM, was conducted with the Director of Nursing (DON) regarding the cleaning and disinfection of shared glucometers. The DON indicated her expectation was for the shared glucometer to be disinfected between each of the resident ' s blood glucose tests. She specifically stated her expectations included that a nurse would wash her hands, put on gloves, clean the glucometer for two minutes, and then let the machine dry completely prior to performing a blood glucose test on a resident. The DON stated the facility policy was to disinfect the glucometer between residents.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025	
(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)	(X6) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/07/2013 the door to the mech. room near room 508 and the mech. room in the smokers court yard containing fuel fired equip. failed to close and latch. 42 CFR 483.70 (a)	K 029	K029 The door to the mechanical room near room 508 and the mechanical room in the smokers courtyard were fixed on 5/7/13 upon identification of problem. All mechanical room doors were additionally checked on 5/7/13 to ensure all were functioning properly, to include closing and latching. Audits will be conducted on a daily basis per the Maintenance Department to ensure all mechanical room doors continue to function properly. Any identified issues will be addressed immediately upon identification. The Executive QI Committee will review the results of the audits upon completion for the continued need of any additional monitoring.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	K076 Unsecured O2 cylinders were removed from the med prep rooms for the 200 and 300 halls upon their identification on 5/7/13. All areas were checked on 5/7/13 for any inappropriate storage of O2 cylinders with removal as needed. Retraining was conducted with all staff on the proper storage of O2 cylinders to include securing of the cylinders and location of the O2 storage room. Retraining will be completed on 5/31/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sharon Kuyler

Administrator 5-24-13

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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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		
(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	
K 076	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 05/07/2013 there were O2 cylinders that were not secured in the Med. Prep. room for the 200 and 300 hall. 42 CFR 483.70 (a)	K 076	The QI Nurse or other Licensed Nurse will audit random locations weekly x 4 to ensure O2 storage is maintained only in its designated location. Additionally the audit will ensure O2 cylinders are properly secured in their designated storage room. The Executive QI Committee will review the results of the audits upon completion for the continued need of any additional monitoring.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345050	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 MAY 29 2013 B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2013
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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system.	K 000	Jacobs Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
K 012 SS=D	The deficiencies determined during the survey are as follows: 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	K 012	Jacobs Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacobs Creek Nursing and Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. K 012	9/6/13
K 038 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 05/07/2013 there are bath fans in residents baths and other small rooms (like soiled utility room) that are not protected nor are they fire rated. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	See attached SEE ATTACHED WAIVER DATE 9/6/13	
	This STANDARD is not met as evidenced by: A. Based on observation on 05/07/2013 the staff			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Kinslet TITLE: Administrator (X8) DATE: 5-24-13

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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		
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K 038	Continued From page 1 interviewed did not know about the master door release switch located at the nurses station. 42 CFR 483.70 (a)	K 038	<p>K038</p> <p>100% of all staff were retrained on the purpose of the master door release at the nurses station. This will be complete by 5/31/2013.</p> <p>100% of all staff were retrained on the purpose and location of all master door releases. This will be completed by 5/31/2013.</p> <p>Door release switches is and will continue to be a part of orientation to all staff.</p> <p>Random audits 3x weekly on all three shifts will be conducted by a qi nurse or a licensed nurse x 2 weeks to ensure continued knowledge of door release.</p> <p>The Executive QI Committee will review the results of the audits upon completion for the continued need of any additional monitoring.</p>	

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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		
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K 038	Continued From page 1 interviewed did not know about the master door release switch located at the nurses station. 42 CFR 483.70 (a)	K 038	<p>K038</p> <p>100% of all staff were retrained on the purpose of the master door release at the nurses station. This will be complete by 5/31/2013.</p> <p>100% of all staff were retrained on the purpose and location of all master door releases. This will be completed by 5/31/2013.</p> <p>Door release switches is and will continue to be a part of orientation to all staff.</p> <p>Random audits 3x weekly on all three shifts will be conducted by a qi nurse or a licensed nurse x 2 weeks to ensure continued knowledge of door release.</p> <p>The Executive QI Committee will review the results of the audits upon completion for the continued need of any additional monitoring.</p>	5-31-13	

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NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025
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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 05/07/2013 the door to the mech. room near room 508 and the mech. room in the smokers court yard containing fuel fired equip. failed to close and latch. 42 CFR 483.70 (a)</p>	K 029	<p>K029</p> <p>The door to the mechanical room near room 508 and the mechanical room in the smokers courtyard were fixed on 5/7/13 upon identification of problem.</p> <p>All mechanical room doors were additionally checked on 5/7/13 to ensure all were functioning properly, to include closing and latching.</p> <p>Audits will be conducted on a daily basis per the Maintenance Department to ensure all mechanical room doors continue to function properly. Any identified issues will be addressed immediately upon identification.</p> <p>The Executive QI Committee will review the results of the audits upon completion for the continued need of any additional monitoring.</p>	
K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p>	K 076	<p>K076</p> <p>Unsecured O2 cylinders were removed from the med prep rooms for the 200 and 300 halls upon their identification on 5/7/13.</p> <p>All areas were checked on 5/7/13 for any inappropriate storage of O2 cylinders with removal as needed.</p> <p>Retraining was conducted with all staff on the proper storage of O2 cylinders to include securing of the cylinders and location of the O2 storage room. Retraining will be completed on 5/31/13.</p>	5-31-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sharon Kaylet* TITLE Administrator 5-24-13 (X6) DATE

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K 076	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 05/07/2013 there were O2 cylinders that were not secured in the Med. Prep. room for the 200 and 300 hall. 42 CFR 483.70 (a)	K 076	The QI Nurse or other Licensed Nurse will audit random locations weekly x 4 to ensure O2 storage is maintained only in its designated location. Additionally the audit will ensure O2 cylinders are properly secured in their designated storage room. The Executive QI Committee will review the results of the audits upon completion for the continued need of any additional monitoring.	