STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING _____ B. WING _____	07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	102 LEONARD AVENUE NEWTON, NC 28658

(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 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to accommodate residents' preference for the frequency of showers per week (Resident #26, #30, #190) and preference for time of day shower was given (Resident #26) for 3 of 3 residents reviewed for choices. The findings included: 1. Resident #26 was admitted on 08/22/11 with diagnoses including Alzheimer's disease, depressive disorder, chronic pain and anxiety. A nursing admission assessment dated 08/23/11 stated bathing required assistance but did not indicate preference for frequency or time of day for showers. An annual Minimum Data Set (MDS) dated 05/07/13 revealed Resident #26 was cognitively intact, was able to make her needs known, and required extensive assistance with bathing. The annual MDS noted rejection of care was not exhibited. The Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) Functional Status dated 05/20/13 stated Resident #26 was	F 242	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Abernethy Laurels of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. Prefix Tag: F242 It is the intent of this facility to ensure that residents have the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the	8/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim H. Harris — TITLE: NHA — (X6) DATE: 8/16/2013

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.

DHSR NHCS Black Mountain WRO Received AUG 28 2013 by: SKH

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ABERNETHY LAURELS	102 LEONARD AVENUE NEWTON, NC 28658

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F 242	Continued From page 1 dependent on staff for assistance with daily personal care tasks and required extensive assistance with transfer, bathing, and toileting. Review of Resident #26's current care plan for ADL revealed she required assistance with ADL due to dementia with the goal to participate in her ADL as able. Interventions included: assist with showers twice weekly. Review of the shower schedule revealed Resident #26 had showers scheduled for Wednesday and Saturday during the 3:00 PM to 11:00 PM shift. An interview was conducted with Resident #26 on 07/23/13 at 9:28 AM. Resident #26 stated she did not have a choice regarding how many times a week she was showered or the time of day they occurred. Resident #26 further stated the staff told her when she was would have a shower and often times it was very late in the evening. The interview further revealed Resident #26 would like to shower every day and during the morning or early afternoon. An interview with nurse aide (NA) #2 on 07/24/13 at 2:50 PM revealed residents received two showers a week and they were assigned by room number. NA #2 stated if a resident requested additional showers she would notify the nurse. NA #2 was not sure how the time of day residents received showers was determined. During an interview on 07/25/13 at 11:10 AM NA #3 stated she worked Monday through Friday during the day shift (7:00 AM to 3:00 PM) and was given a list every morning of which residents needed showers during the day shift. NA #3	F 242	community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice: Residents #26, #190 and #30 were interviewed on July 24, 2013 during survey for bathing frequency preference by the Director Nursing. Resident #26 desired to have her bathing time changed from evening to morning. Residents #190 refused to have her bath time or frequency changed. Resident #30 desired to have a bath 7 days a week. Both the Kardex and Plan of Care have been updated to reflect changes in bathing schedule preference.. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On July 24, 2013 all interviewable health center residents were interviewed for bathing frequency and time of day bathing occurs. Residents desiring baths more often or desiring a change in the time of day were accommodated into the weekly bathing schedules. The Kardex and Plan of Care was updated for each resident accordingly.	8/18/13

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F 242	Continued From page 2 further stated the unit managers put the residents on the shower schedule and she was not sure how the time of day a shower was given was determined. An interview was conducted on 07/25/13 at 1:05 PM with the Director of Nursing (DON). The DON stated residents received two baths/showers per week and if they requested more they could be scheduled. The DON stated prior to yesterday residents' preference for frequency of showers was not assessed. An interview was conducted with Nurse #2 (Unit Manager) on 07/25/13 at 2:10 PM. Nurse #2 stated residents were assessed for their preference regarding a shower or bath during the admission process. Nurse #2 further stated frequency and time of day for bathing was not formally addressed during the admission process but if the resident wanted more showers the request would be accommodated. 2. Resident #190 was admitted to the facility on 03/10/13 with diagnoses including Alzheimer's dementia, degenerative joint disease with nerve impingement, and neuropathy. A quarterly Minimum Data Set (MDS) dated 06/04/13 revealed Resident #190 had moderately impaired cognition, was able to make her needs known, and required extensive assistance with bathing. The Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) Functional Status dated 03/12/13 stated Resident #190 was dependent on staff for assistance with daily personal care tasks and was totally dependent on staff for bathing.	F 242	3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur: The Introductory Meeting questionnaire has been updated to reflect bathing preferences including frequency, bath or shower and time of day. This questionnaire will be completed by the Interdisciplinary Team during the admission process. The Health Center Admission Checklist has also been updated to include bathing preference for frequency, time of day, and whether they prefer a bath or shower. All residents will be re-interviewed during their quarterly care plan meeting for bathing preferences. Any updates to bathing preferences will be communicated to Nursing Assistants by the Unit Nurse Manager and/or Charge Nurse on the Hall. A nursing assistant work sheet is provided daily with updates on bathing preferences. The updated Kardex at the Kiosk will also serve as a means of communication to Nursing Assistants for any changes in bathing preferences. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system.	9/18/13

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F 242	Continued From page 3 Review of Resident #190's current care plan for ADL revealed she required assistance with ADL due to dementia, degenerative joint disease with nerve impingement, neuropathy, and chronic pain. The goal was for her to participate in her ADL as able. Review of the shower schedule revealed Resident #190 had showers scheduled for Tuesday and Friday during the 7:00 AM to 3:00 PM shift. An interview was conducted with Resident #190 on 07/23/13 at 11:52 AM. Resident #190 stated she would like more than two showers a week but no one had ever asked her what her preference was regarding frequency of showers. An interview with nurse aide (NA) #2 on 07/24/13 at 2:50 PM revealed residents received two showers a week and they were assigned by room number. NA #2 stated if a resident requested additional showers she would notify the nurse. During an interview on 07/25/13 at 11:10 AM NA #3 stated she worked Monday through Friday during the day shift (7:00 AM to 3:00 PM) and was given a list every morning of which residents needed showers during the day shift. NA #3 further stated the unit managers put residents on the shower schedule and if a resident requested additional showers she would notify the unit manager or nurse. An interview was conducted on 07/25/13 at 1:05 PM with the Director of Nursing (DON). The DON stated residents received two baths/showers per week and if they requested more they could be scheduled. The DON stated prior to yesterday	F 242	The Administrator and Director of Nursing will review and sign the revised health center admission checklist for all new residents moving into the health center. These measures will be monitored by the Administrator and Director of Nursing through the Quality Assurance process. The Administrator and/or Director of Nursing will report on the measures implemented to the QAPI Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	8/18/13

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F 242	Continued From page 4 residents' preference for frequency of showers was not assessed. An interview was conducted with Nurse #2 (Unit Manager) on 07/25/13 at 2:10 PM. Nurse #2 stated residents were assessed for their preference regarding a shower or bath during the admission process. Nurse #2 further stated frequency and time of day for bathing was not formally addressed during the admission process but if the resident wanted more showers the request would be accommodated. 3. Resident #30 was readmitted to the facility on 03/18/13 with diagnoses which included peripheral vascular disease, diabetes, congestive heart failure and hypertension. Resident #30's most recent Quarterly Minimum Data Set (MDS) assessed her as being cognitively intact. The MDS further assessed Resident #30 as needing limited assistance with most activities of daily living and needing the physical assistance of one person with bathing. An interview was conducted on 07/23/13 at 8:03 AM with Resident #30. Resident #30 stated she received two showers per week but she would like to have a shower every night. She stated she told the staff but she was told it was the rule she could only have two per week. An interview was conducted on 07/24/13 at 3:01 PM with Nursing Assistant (NA) #1. NA #1 stated she works with Resident #30 on 2nd shift (3:00 PM to 11:00 PM). NA #1 stated she knew what to do for residents just by having worked with them for some time. She further stated there was an	F 242		8/18/13

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F 242	Continued From page 5 index in the computer kiosk which tells exactly what needs to be done for each resident. She stated showers were assigned and the shower schedule tells who gets showers on each day. NA #1 revealed showers were typically given twice per week though one resident gets one three times per week because it is needed. NA #1 went on to explain if a resident requested more than two showers per week they would get a sponge bath because there is a limit to what they can get done. She stated there were two NAs who work the 200 hall and they give 2 to 3 showers during 2nd shift. An interview was conducted on 07/24/13 at 3:18 PM with Nurse #1 (Unit Manager). Nurse #1 stated the shower schedule was twice per week based on the resident's room number. She went on to explain that the schedule can change due to resident preferences regarding day or evening shower. Nurse #1 explained that during the admission process residents are asked if they would like a tub bath or a shower but not how frequently they would like a shower or a bath. Nurse #1 stated residents were told what their shower days were and if they requested more they would receive more. An interview was conducted with Resident #30 on 07/25/13 at 10:10 AM. Resident #30 stated she has told several people she was wanted a shower every night. She stated she told NA#1 but was not sure if she told the nurses. She stated she wanted her showers every night because she likes to feel clean before she goes to bed. An interview was conducted on 07/25/13 at 1:05 PM with the Director of Nursing (DON). The DON stated residents receive two baths per week and	F 242		8/15/13

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F 242	Continued From page 6 if they want more they can schedule more. She stated a resident can get a tub bath or a shower. The DON stated prior to yesterday residents' preference for frequency of showers was not something they assessed.	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to order and obtain a Physician ordered laboratory test for 1 of 10 residents reviewed for Physician's orders. (Resident #28). The findings included: Resident #28 was admitted on 04/30/13 with diagnoses including post-polio syndrome, irritable bowel syndrome diarrhea, and right below the knee amputation. Further review of the medical record revealed a Physician's order dated 07/01/13 for a CBC (complete blood count) in two weeks. Review of laboratory test results revealed a CBC with a differential white blood cell count was completed on 06/28/13. There were no results for a CBC drawn in July of 2013 located in the medical record. During an interview on 07/25/13 at 1:50 PM Nurse #2 (Unit Manager) confirmed Resident	F 281	Prefix Tag: F281 It is the intent of this facility to provide services that meet professional standards of quality. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. On July 25, 2013 a CBC was drawn for resident #28, results reviewed and found to be within normal limits. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Lab orders were reviewed for residents by the Unit Nurse Managers and Director of Nursing beginning on July 26, 2013. All lab orders were found to be current and in compliance. 3) Measures to be put into place or systemic changes made to ensure	8/18/13

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F 281	Continued From page 7 #28's CBC had not been ordered or obtained per the Physician's order dated 07/01/13. Nurse #2 stated the Physician had ordered the CBC to follow up on low hemoglobin results noted on the CBC obtained on 06/28/13. The interview further revealed the nurse who signed off the laboratory order was responsible for writing the order on a communication slip for the unit secretary so the order could be entered into the computer. Nurse #2 could not explain why the CBC had not been ordered for Resident #28 but did say the usual unit secretary for the North nursing unit did not work on 07/01/13. An interview was conducted with the Director of Nursing (DON) on 07/25/13 at 1:55 PM. The DON stated the 3rd shift (11:00 PM to 7:00 AM) nurses completed 24 hour chart checks daily to assure all orders were completed. The interview further revealed the nurse completing the 24 hour chart check was expected to verify the communication slip was in the laboratory box for the unit secretary to process. The DON stated she felt Resident #28's CBC was omitted due to human error but she expected laboratory tests to be ordered and obtained per the Physician's order. An interview with the Unit Secretary on 07/25/13 at 2:30 PM revealed when she received a laboratory order she transferred the information to an index card and placed the card behind the corresponding month tab in the laboratory box. The interview further revealed the unit secretary did not have record of Resident #28's order dated 07/01/13 for a CBC in two weeks.	F 281	<u>that the alleged deficient practice will not occur.</u> In-service education was conducted by the Director of Nursing for licensed nurses and unit secretaries for all shifts on July 30, 2013 regarding the current system of monitoring labs. An index card tickler file was created wherein new lab orders are placed according to the date they are to be drawn. The location of the index card tickler file holder was communicated to licensed nurses who conduct 24 hour chart checks. Labs are being verified during the 24 hour chart checks. <u>4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system.</u> Lab orders from the previous 24 hours will be monitored and compared to the card tickler system for compliance by the unit secretary with oversight by the Director of Nursing. The unit secretary compares labs from a carbon of the original order to the card tickler system. The Director of Nursing will report on the measures implemented to the QAPI Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see	8/13/13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 8 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility documents and staff interviews the facility failed to initiate their bowel protocol for 3 of 10 residents reviewed for constipation (Residents # 1, #35, #70). The findings included: Review of the facility document titled "Bowel Protocol" dated 01/16/2006 and signed by the medical director 10/15/2010, read in part: 1. The 3-11 charge nurse will check the BM (bowel movement) record each evening. 2. If a resident has not had a bowel movement within 3 days, one Dulcolax (laxative) pill will be given by mouth and recorded on the resident's MAR (Medication Administration Record). 3. The following day (day 4 no BM), if the resident has not had a bowel movement -no results from one Dulcolax pill the evening before, two Dulcolax (or generic equivalent) pills will be given in the evening and recorded on the MAR. 4. If the resident does not have results from the two Dulcolax (or generic equivalent) pills given above, the day shift nurse on the 5th day will complete a rectal check and administer a Fleet (or generic equivalent) phosphate or mineral oil	F 309	that recommendations are acted upon in a timely manner. Prefix tag: F309 It is the intent of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Residents #1, #35 and #70 were reviewed and bowel movement protocol is being followed with appropriate results. The protocol requires one Dulcolax to be given after 72 hours of having no bowel movement. The next evening two Dulcolax are given if no results. If resident doesn't have results from this intervention, the next day shift nurse will complete a rectal check and administer the appropriate enema. If no results are achieved after the enema, then the physician is contacted. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice:	8/18/13

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F 309	Continued From page 9 enema or a soap suds enema, The enema type and results will be documented on the MAR. 5. If no results are achieved, contact the physician. 1. Resident #35 was admitted to the facility on 05/08/13 with diagnoses which included diabetes and chronic kidney disease. Resident #35's most recent Significant Change Minimum Data Set (MDS) assessed her as having moderate cognitive impairment. The MDS further assessed Resident #35 as needing extensive assistance with all activities of daily living including toilet use. Review of Resident #35's bowel records revealed she had not had a bowel movement for 12 consecutive days, from 06/26/13 through 07/06/13. Review of the June 2013 MAR revealed on 06/29/30 Dulcolax (a laxative) 5 milligrams (mg) was given at 4:57 PM. On 06/30/13 at 9:41 AM the results of the laxative were documented as having "no effect." On 06/30/13 Resident #35 was given Biscolax (a laxative) 10 mg at 9:49 AM. On 06/30/13 at 6:02 PM the results of the laxative were recorded as having "no effect." Further review of the June 2013 and the July 2013 MARs revealed there were no other medication interventions for constipation given to Resident #35 until 07/06/13. On 07/06/13 Resident #35 was again given a laxative. An interview was conducted on 07/25/13 at 2:00 PM with the Assistant Director of Nursing (ADON). The ADON confirmed after reviewing Resident #35's the bowel records; she had not had a bowel movement for 12 consecutive days.	F 309	Bowel movement records were reviewed for residents. The bowel movement protocol was initiated for anyone identified as not having a bowel movement within 72 hours. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. The Bowel Movement protocol was reviewed and updated on July 29, 2013 in conjunction with the Medical Director and Director of Nursing. Staff was educated on July 30, 2013 by the Director of Nursing regarding accurate documentation being crucial in order to follow the updated Bowel Movement protocol. Nursing Assistants are documenting bowel movements on the kiosks in HealthMedX and all paper documentation has been eliminated. Licensed nurses receive a list of residents having no bowel movements within the last 72 hours each day, which is generated by HealthMedX. Unit Nurse managers review this information and initiate the bowel movement protocol. A communication form is being used by licensed nurses to follow up on results of PRN laxatives up to the need to contact the physician if no results are achieved. 4) Facility's plan to monitor its performance so solutions are	8/15/13

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F 309	Continued From page 10 The ADON stated the resident should have received an enema after the Dulcolax was administered on 06/30/13 and Resident #35 did not have a bowel movement. An interview was conducted on 07/25/13 at 3:21 PM with the Director of Nursing (DON). The DON stated when a resident had gone 9 shifts without a documented bowel movement a report is generated by their computer system. This report is given to the nurses so they can initiate the bowel protocol for these residents. The DON stated it was her expectation for the bowel protocol to have been followed. 2. Resident #1 was admitted to the facility with diagnoses which included anemia, hypertension and arthritis. Resident #1's most recent Significant Change Minimum Data Set (MDS) dated 06/25/13 assessed her as being cognitively intact. The MDS further assessed Resident #1 as having total dependence for most activities of daily living including toileting. Review of the facility's documentation of resident bowel movements revealed Resident #1 had not had a bowel movement for 6 consecutive days, 07/06/13 through 07/11/13. Review of Resident #1's Medication Administration Record for July of 2013 revealed no medication interventions were initiated for her constipation. An interview was conducted on 07/25/13 at 2:07 PM with the Assistant Director of Nursing (ADON). The ADON confirmed Resident #1 had not had a bowel movement for 6 consecutive days, 07/06/13 through 07/11/13. The ADON	F 309	sustained and integrated into the facility's quality assurance system. These measures will be monitored by the unit Nurse Managers with oversight by the Director of Nursing through the Quality Assurance process. The Director of Nursing will report on the measures implemented to the QAPI Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	8/18/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING _____ B. WING _____	07/25/2013

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F 309	Continued From page 11 stated the nurse should have started the bowel protocol for Resident #1 if she had not had a bowel movement in three days. An interview was conducted on 07/25/13 at 3:21 PM with the Director of Nursing (DON). The DON stated when a resident had gone 9 shifts without a documented bowel movement a report is generated by their computer system. This report is given to the nurses so they can initiate the bowel protocol for these residents. The DON stated it was her expectation for the bowel protocol to have been followed. 3. Resident #70 was admitted to the facility on 05/11/09 with diagnoses which included congestive heart failure (CHF) and hypertension (HTN). Review of Resident #70's most recent Significant Change Minimum Data Set (MDS) dated 05/20/13 revealed she was cognitively intact. The MDS further revealed Resident #70 was incontinent of bowel and bladder and needed extensive assistance with toileting. Review of physician orders dated for the month of June 2013 revealed the following orders for constipation: Colace 100 milligrams (mg) one capsule by mouth daily Benefiber one scoop mixed in liquid by mouth three times per day Review of the facilities standing orders (protocol) on Resident #70's medical record revealed the following for constipation:	F 309		8/18/13

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F 309	Continued From page 12 Dulcolax 5mg capsule by mouth as needed (PRN) for constipation, Fleets Enema one per rectum every 24 hours as needed (PRN), and If no bowel movement contact physician. Review of Resident #70's care plan dated 01/29/13 revealed Resident #70 required the total assistance of staff with all activities of daily living (ADL), toileting, and was incontinent of bowel and bladder. In addition nurse aides would give incontinence care frequently per protocol and document the number of incontinent episodes each shift and if no bowel movement in 3 days the bowel protocol was to be initiated. Review of the "Bowel and Bladder Report" for the last 30 days for Resident #70 revealed a bowel movement (BM) was documented on 07/01/13 after Dulcolax 10mg's was administered. No other bowel movements were documented until 07/11/13 (9days). Further review of the "Bowel and Bladder Report" revealed a bowel movement (BM) for Resident #70 on 07/17/13 on 2nd shift and not again until 07/23/13 on 1st shift (5 days) after Dulcolax 5mg was administered on 07/22/13. Review of the Medical Record for Resident #70 revealed there was no documentation the physician had been contacted regarding constipation during the time frame of 07/02/13 and 07/11/13 or during the time frame of 07/17/13 and 07/22/13, with no attempt of a Fleets Enema for the month of July 2013 for Resident #70. Review of the Medication Administration Record (MAR) dated the month of July 2013 revealed	F 309		8/15/13

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F 309	Continued From page 13 Resident #70 was administered Colace and Benefiber each day. An interview on 07/25/13 at 2:15 PM with Resident #70 revealed she was unaware of when she needed to go to the bathroom or if she received any medications for constipation. An interview was conducted on 07/25/13 at 2:45 PM with the Assistant Director of Nursing (ADON). The ADON stated the unit secretaries were to print the no bowel movement in 3 days report daily and give the report to the nurse assigned to the hall for their review. The nurses were expected to utilize the information to determine which residents on their assigned hall needed a laxative. The ADON reviewed Resident #70's medical record, bowel movement records, and nurses' notes and confirmed there was no documentation regarding bowel assessments, physician notification, and/or implementation of an intervention when Resident #70 experienced more than 3 days with no bowel movement. An interview was conducted on 07/25/13 at 3:21 PM with the Director of Nursing (DON). The DON stated when a resident had gone 9 shifts (3 days) without a documented bowel movement a report was to be generated by their computer system. The report was to be given to the nurses so they could initiate the bowel protocol for their assigned residents. The DON stated it was her expectations for the bowel protocol to have been followed. She further stated she was unaware the protocol had not been followed.	F 309		8/18/13
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 14 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to provide a dependent resident assistance with oral hygiene for 1 of 3 residents reviewed for activities of daily living (Resident #189). The findings included: Resident #189 was admitted on 04/27/12 with diagnoses including left total knee replacement, arthritis, cardiomegaly, and chronic hypoxia. A quarterly Minimum Data Set dated 06/04/13 revealed Resident # 189 had moderately impaired cognition and was able to make her needs known. The quarterly MDS further revealed Resident #189 required extensive assistance with personal hygiene and rejection of care was not noted. Review of a care plan for activities of daily living (ADL) dated 03/06/13 revealed Resident #189 required assistance with ADL due to a history of left total knee replacement resulting in decrease function. The stated goal was for Resident #189 to have her ADL needs met with staff assistance for the next 90 days. Interventions included: assist with dressing, grooming, and personal hygiene daily, and set up for mouth care and assist as needed.	F 312	Prefix tag: F312 It is the intent of this facility to provide the necessary services to maintain good nutrition, grooming and personal and oral hygiene for those residents who are unable to carry out activities of daily living. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Mouth care was provided for resident #189 on July 25, 2013 and continues on a daily basis. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Residents were offered and provided mouth care during morning and evening ADL care. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Education was provided to Nursing Assistants regarding mouth care as	8/19/13

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F 312	Continued From page 15 A Care Area Assessment (CAA) Summary for ADL Functional Status dated 03/15/13 stated Resident #189 was dependent on staff for assistance with daily personal care tasks. The CAA also revealed Resident #189 required extensive to total assistance with transfers, dressing, eating, toileting, and personal hygiene. During an interview on 07/22/13 at 12:06 PM Resident #189 stated staff assisted her with brushing her teeth about once a week and this was not frequent enough. Resident was observed moving her tongue over her teeth to remove food debris. Resident #189 further stated no one had assisted her with oral hygiene that morning. On 07/23/13 at 9:00 AM Resident #189 stated she had received a shower earlier but was not assisted with brushing her teeth. During a follow up interview on 07/24/13 at 9:30 AM Resident #189 stated she had not been assisted with brushing her teeth that morning and she forgot to ask her son to help her brush her teeth when he visited on 07/23/13. Resident #189 was observed using her tongue to remove grits from her teeth. An interview with nurse aide (NA) #4 on 07/24/13 at 1:30 PM revealed Resident #189 required assistance with ADL including brushing her teeth. NA #4 stated she had not assisted Resident #189 with oral hygiene that morning because she got busy. An interview was conducted with the Director of Nursing (DON) on 07/25/13 at 1:45 PM. During the interview the DON stated she expected NAs to brush residents teeth at least twice a day.	F 312	being part of morning and bed time ADL/Personal Care when being documented daily at the kiosks for HealthMedX on July 30, 2013 by the Director of Nursing. The Staff Development Coordinator also provided in-service education to nursing assistants using "The Mouth Care Without a Battle" video on August 16, 17, 18, 2013. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. Weekly QAPI mini audits will be completed by administrative staff on each hall. These measures will be monitored by the Charge Nurse with oversight by the Director of Nursing through the QAPI checklist. The Director of Nursing will report on the measures implemented to the QAPI Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	8/18/13
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=E	Continued From page 16 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove dented canned food stored ready for use. The findings included: An initial tour of the facility's kitchen was made on 07/22/13 at 12:35 PM with the Food Service Director (FSD). During the tour, observations of the dry good storage area revealed 5 cans of fruit with rim dents. The dents were approximately 3-4 inches long just above the bottom rim of the canned goods. The FSD was present for the observation and reported that the canned goods were stored ready for use. He added that food service employee #1 had been trained on the procedure for stocking canned goods. He added that the employee was trained to inspect stock and remove damaged canned goods. The FSD removed the 5 damaged cans. He stated the damaged cans should have been stored on the shelf ready for use in food production. Food service employee #1 was not available for	F 371	Prefix Tag: F371 It is the intent of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. 1) Corrective action to be accomplished for those residents to have been affected for those residents having potential to be affected by the same alleged deficient practice: Dented cans identified during the survey were removed from storage by Dietary Staff on July 22, 2013. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: All food storage areas were inspected on July 22, 2013 to verify no dented cans remained in storage. The Director of Dietary verified that cooks know not to use dented cans for meal preparation if they find dented cans in the storage area. 3) Measures to be put into place or systemic changes made to ensure	8/19/13

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F 371	Continued From page 17 an interview. On 07/24/13 at 11:50 AM the Food Service Manager was interviewed and reported that she expected all dented cans to be removed and placed on a shelf designated for damaged cans. She added that food service employee #1 had been out and that food service employee #2 had also helped with stocking canned goods. She added that she wasn't sure which employee failed to remove the dented cans but that both employees had been trained to remove dented canned goods from use.	F 371	<u>that the alleged deficient practice will not occur:</u> All dietary staff who could be responsible for storage and receiving stock were educated on August 15, 2013. A dented can area was established near the Chef's office on July 22, 2013. <u>4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system:</u> These measures will be monitored by the Director of Dietary through the weekly Food Safety Walkthrough with oversight by the Chef. The Director of Dietary will report on the measures implemented to the QAPI Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	8/16/13
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to prevent fly activity in the kitchen. The findings included: An initial tour of the kitchen was made on 07/22/13 at 12:35 PM. The observations revealed that the main entrance door into the kitchen was propped open. The door remained propped open the entire time of the initial tour. Additional observations of the door revealed the door remained open to the service entry 07/22/13 at 12:35 PM, 07/23/13 at 9:50 AM and 07/24/13 at 11:20 AM. Adjacent to the main entrance door	F 469	Prefix Tag: F469 It is the intent of this facility to maintain an effective pest control program so that the facility is free of pests and rodents. <u>1) Corrective action to be accomplished for those residents to</u>	

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F 469	Continued From page 18 was an exterior door that led to the staff parking lot. The exterior door was noted to be used by staff on 07/22/13 at 12:40 PM and on 07/24/13 at 11:50 AM. Observations of the kitchen area revealed 2 fly lights used to reduce fly activity in the kitchen. Additional observations were made on 07/24/13 at 11:50 AM that revealed the lunch meal tray line in progress. A fly was noted on the dishware used for resident food. During the course of the lunch meal tray service fly activity increased and 4 flies were observed swarming around the food and on the dishware served to residents. During the observations, food service employees were noted to swat the flies away from the food. The Registered Dietitian (RD) was present for the observations and confirmed the flies were problematic and seemed to be getting worse. Food service employee #3 commented the flies had started to become a problem. On 07/24/13 at 2:00 PM the Food Service Manager was interviewed and reported that she had not noticed fly activity in the kitchen area and that she had not received concerns about fly activity in the kitchen. She stated she would expect staff to report concerns to her. In addition she reported that staff utilized an exterior door that led to the dumpster area and that use of the door could allow flies into the food production area. Also, she stated that the main entrance door into the kitchen should probably be kept shut to prevent flies from entering the kitchen area. The Food Service Manager added that the kitchen had 2 fly lights to reduce fly activity in the kitchen.	F 469	have been affected by the alleged deficient practice. The four flies observed in over 5,000 square feet of kitchen area were taken care of through the Ecolab system in place. The Ecolab system uses an ultraviolet light and a scented bait attractant to lure and eliminate flying insects. Dietary staff observed no continued evidence of flies during audits of the kitchen area during the time of the survey. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Ecolab pest control specialists visited on July 25, 2013 and found no insect activity during their thorough inspection of the kitchen and dining areas. Inspections by Ecolab are scheduled monthly. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Dietary staff were educated on minimizing time doors are open during deliveries on August 15, 2013 by the Regional Manager of Sodexo. Staff were also educated on timely reporting of identified insects to their supervisor during this same in-service. Ecolab continues to thoroughly inspect the kitchen and	8/18/13

dining areas each month per our contract and additionally on an as needed basis.

4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system.

These measures will be monitored through the monthly Food Safety audit with oversight by the Director of Dietary. The Director of Dietary will report on the measures implemented to the QAPI Committee which will monitor effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.

8/18/13

8/18/13