

AUG 26 2013

AUG 28 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: 345249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/09/2013
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY EDEN, NC 27288	
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F 166 SS=E	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, and staff interviews the facility failed to address grievances for 4 of 4 residents (Resident #129, 50, 16 and 31) reviewed for grievances.</p> <p>Findings Included:</p> <p>The Grievance/Complaints Policy dated 10/1997 stated, "Grievances and/or complaints may be submitted orally or in writing."</p> <p>The Grievance/Complaints Policy dated 10/1997 stated, "The Administrator has assigned the responsibility of Investigating grievances and complaints to the Nursing Supervisor. Upon receipt of a Grievance, the Supervisor will begin and investigation. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten working days of the filing of the grievance or complaint. A copy of the investigation Report must be attached to the Grievance Report and filed. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident."</p> <p>The Grievance/Complaints Policy dated 10/1997 stated, "Should a staff member overhear or be</p>	F 166	<p><i>F 166</i></p> <p>1. The affected residents and/or resident family member have been contacted via phone or in person to ensure that current/past grievances are resolved. All affected residents and/or resident family members will be contacted at least once a week to check if there are any grievances/concerns. The communication with the resident and/or family member will be completed by the Clinical Nurse Manager and/or designee.</p> <p>2. A monthly sample of 10 current resident and/or resident family member grievances will be completed. As part of this sample, the appropriate Department Head and/or designee will follow up on with the resident and/or family member about the grievance to ensure resolution.</p>	9/9/13

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

TITLE

(X6) DATE

Michael A. Jones Administrator

8/28/13

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 166	<p>Continued From page 1</p> <p>recipient of a complaint voiced by a resident, a resident's representative, or another interested family member of a resident concerning the resident's medical care, treatment ...the staff member should encourage and assist the resident, or person acting on the resident's behalf, to file a written complaint with the facility. Staff members should inform the resident or the person acting on the resident's behalf that an ample supply of Grievance and Complaint Report forms is available at each nurse's station and the procedures for filing a grievance or complaint are posted on the residents' bulletin board."</p> <p>Record review of the grievance logs revealed no documentation of grievances or complaints by Resident #129, 50, 16, or 31.</p> <p>1. During an interview on 8/8/13 at 3:45 pm with Resident #16's family member, Family Member #2 indicated concerns related to staffing, call bell lights not being answered, residents having to wait so long for toileting that they become incontinent, and nurse's not providing care. She indicated that both she and [another family member], who visit the resident daily, had voiced these concerns to the Director of Nursing (DON), was not aware of any concern being put in writing, had not received notification of any findings or corrective actions, and the care concerns had not improved over the past six months.</p> <p>During an interview on 8/9/13 at 3:21 pm, the DON indicated she had received concerns from two of Resident #16's family members and she had not placed any of the concerns in writing. She indicated grievances should be in writing and</p>	F 166	<p>3. All residents and/or resident family members' grievances will be documented on a Grievance Report Form. The appropriate Department Head and/or designee will investigate the grievance/concern and attach the findings to the Grievance Report. The outcome of the grievance investigation will be communicated to the resident and/or resident family member via phone or in person.</p> <p>4. The Administrator and/or designee will conduct random audits of the Grievance/Concern Log to ensure a resolution has been achieved and communicated to the resident and/or resident family member. The results of these audits will be reviewed quarterly during Quality Assurance meetings.</p> <p>5. September 9, 2013</p>	

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F 166	<p>Continued From page 2</p> <p>followed up on with the complainant. She further stated, "A [family member] went to the Chief Nursing Officer and it was brought to our attention. The issues she took over there were the same ones she brought up over here." The DON confirmed she had no documentation of any concerns or grievances related to Resident #16 and she was aware there had been "several concerns."</p> <p>2. During an interview on 8/8/13 at 4:21 pm with Resident #129's visitor/advocate, she indicated she and the resident's family member visit the resident for about 7 hours each day. She indicated concerns related to insufficient staffing to provide care, call bell lights not being answered, and long waits for toileting. She indicated she had spoken with the DON about these complaints, was not aware of anything in writing, was not aware of any corrective action. She indicated the concerns had not improved.</p> <p>During an interview on 8/9/13 at 3:21 pm, the DON indicated she did not remember Resident #129's visitor/advocate voicing any concerns. The DON confirmed she had no documentation of any concerns or grievances related to Resident #129.</p> <p>3. During an interview on 8/9/13 at 12:39 pm with Resident #50's family member, Family Member #3 indicated concerns with resident care that included toileting, incontinent care, and call bell lights not being answered. She indicated she visits almost daily and is unable to "just sit and visit" because of insufficient staffing and the resident not receiving care. She indicated she has spoken with both the Administrator and the DON regarding her concerns, was not aware of</p>	F 166			

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F 166	<p>Continued From page 3</p> <p>any complaint or grievance being put in writing, was not aware of any corrective action or follow up, and indicated her concerns regarding care had not been handled.</p> <p>During an interview on 8/9/13 at 3:21 pm, the DON indicated she was aware of "multiple issues" of concern regarding Resident #50's care. She stated, "I think there was a grievance filed for wet clothes in the closet. I don't remember about the others." The DON confirmed she had no documentation of concerns or follow up from concerns related to Resident #50.</p> <p>During an interview on 8/9/13 at 5:00 pm with the Administrator, he indicated that grievances or complaints should be in writing on a concern form, should indicate the concern, how the concern was handled, and communication to the person who filed the grievance/complaint. He also indicated the DON was the staff person assigned to handle any grievance related to care.</p> <p>4. During an interview on 8/8/13 at 12:06 PM with Resident #111 's family member, Family Member #1 indicated concerns with staffing. Family Member #1 stated there were often times only one aide on an entire hall at one time and sometimes there were 2 aides. Family Member #1 indicated he had spoken with the Administrator and the DON about his concerns several times and stated the Administrator stated they have</p>	F 166			

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F 166	Continued From page 4 staff who call in and they are shorthanded but the nurses on each unit are expected to help the aides.	F 166			
F 241 SS-E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, family and staff interviews the facility failed to ensure resident's call bells were answered, resulting in embarrassment and loss of dignity for 7 of 7 residents. (Residents # 189, #16, #65, and #129.) 1. Resident # 189 was admitted on 5/21/13 with the diagnosis of hypertension, hyperlipidemia, and stroke with left sided paralysis. The current Minimum Data Set (MDS) revealed Resident #189 had no short or long term memory loss and was able to make decisions of her daily care. She	F 241			

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F 241	<p>Continued From page 5</p> <p>required extensive assistance with toileting, bed mobility, dressing, personal hygiene and bathing. She required assistance with balance moving from surface to surface. She also had an impairment of one side of her body (left sided paralysis).</p> <p>Review of care plan dated 6/3/13 revealed Resident #189 had bowel and bladder incontinence and dependence on staff for toileting assistance. Interventions included in part, encourage resident to call for assistance with toileting and to offer toileting assistance on each round.</p> <p>Review of care plan dated 6/3/13 revealed Resident #189 needed extensive to total ADL (activities of daily living) assistance following a stroke with L (left) sided weakness and inattention. Interventions included in part, set-up for ADL and assist as needed (L arm flaccid).</p> <p>During an interview on 8/5/13 at 3:20 pm, Resident #189 indicated she was not able to control urination and during the night she used a bedpan. She revealed on 6/29/13 she had been left on the bed pan for hours on the 7pm-7am shift. She managed to slide herself off the bed pan. She felt disregarded and forgotten. The incident was reported to the Director of Nursing (DON) the next morning.</p> <p>During an interview on 8/9/13 at 11:25am, Resident #189 indicated on 8/4/13, during the 7:00pm -7:00 am shift she needed the bed pan and rang the call bell for care. Before the aide had arrived she was incontinent of bowel and had to lay in soiled clothing and bedding. It smelled</p>	F 241	<p><i>F241</i></p> <p>1. The affected residents' care plan has been updated and reviewed with direct care staff to ensure that there is a clear understanding of the resident's individual needs and how their needs can be met. The Administrator, Director of Nursing, and/or designee will review and update affected residents care plans, with the assistance of appropriate staff. The Clinical Nurse Manager and/or designee will communicate the updated care plan to the direct care staff. The affected residents and/or resident family member have been contacted via phone or in person to ensure that the residents' call bell is being answered timely.</p>	9/20/13	

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F 241	<p>Continued From page 6</p> <p>awful and she felt embarrassed. When Aide #10 arrived to provide incontinent care she apologized indicating they were short of staff. Aide #10 was not available for interview.</p> <p>2. Resident #16 was admitted to the facility on 9/9/05 and readmitted on 6/12/12 with diagnoses that included history of falls, muscle weakness, heart failure, hypertension, and osteoporosis.</p> <p>The annual MDS dated 6/3/13 indicated the resident was cognitively intact, required extensive assistance with toileting, was frequently incontinent, and participated in the assessment.</p> <p>The care plan updated 6/17/13 indicated, "Frequent episodes of urinary incontinence. Extensive toileting assist needed." Interventions included, " Assist with incontinence care as needed, encourage resident to call for assistance with toileting, and keep call light within easy reach. "</p> <p>During an interview with Resident #16 on 8/8/13 at 3:28 pm she stated, "There is not nearly enough help. When I ring the call bell it is a long, long time before they can get here. The aides are so busy." Resident #16 indicated she has had to "wait over 20 minutes many times " for her call bell to be answered and that nurses would come into her room, turn off the call bell, and tell her they would let her aide know she needed assistance. She indicated she would then have to wait lengthy periods of time before an aide could help her. She stated that she was " forced to wet myself " due to her call bell not being answered and, "I have been put on the toilet and left there so long that I used my phone and called my [family member] to come to the</p>	F 241	<p>2. A monthly sample of 10 current resident care plans will be completed. As part of this process, the Director of Nursing, MDS Coordinator, and/or designee will review the residents within the sample to ensure accuracy and that the residents care plan is being addressed daily. The sample residents and/or resident family member will be contacted via phone or in-person to ensure that the residents' call bell is being answered timely.</p> <p>3. All staff will be in-serviced on the importance of Resident Dignity and Respect. All staff will also be in-serviced on the importance of teamwork and how effective teamwork has a positive impact on our residents.</p>		

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F 241	<p>Continued From page 7</p> <p>facility and got me off the toilet." Resident #16 indicated having to wait so long for assistance and having to be incontinent due to waiting made her feel embarrassed, frustrated, and feel badly "especially for those resident's who can't speak for themselves and don't have family to help them."</p> <p>During an interview on 8/8/13 at 3:45 pm Family Member #2 indicated she visits Resident #16 daily and stated, " I have been here when [Resident #16] has pushed her call bell to go to the bathroom and has waited 20 minutes or more. I have requested from the nurses sitting at the nurse ' s station, when the aides were all busy, to help her and the response has been, ' Let me find her aide.' I don't know why the nurses cannot help. Last Saturday I came in at 2:50 pm and [Resident #129] was in her room. I smelled feces and went to see where it was coming from. It was her. I went to the nurse ' s station and told someone that she needed changing. At 4 pm when I left, the smell was just as bad. I am sure she had not been changed as bad as the smell was."</p> <p>During a continuous observation of Resident #16's hallway on 8/8/13 from 4:00 pm - 4:18 pm, call lights for rooms 136 and 137 were observed on in the hallway and were audible from the nurse's station. Nurse #1, Nurse #2, and Nurse #3 were at the nurse's station, talking. The DON was also standing at the nurse's station. There were no aides visible in the hallway. When asked whether the aides assigned to the observed hallway were on break or providing care, the DON stated, " When [aides] leave the floor for break [they] report off to the nurse. None are on break right now. They are providing care." When</p>	F 241	<p>4. The Social Worker and/or designee will complete a random survey to monitor how residents and /or resident family members feel the facility is meeting their need in regards to dignity and respect.</p> <p>5. September 20, 2013</p>		

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F 241	<p>Continued From page B</p> <p>asked about the 2 call lights that had been ringing for 18 minutes she stated, "It is my expectation that nurses answer call bells if the aids are not available. I answer call bells when I am walking the halls and I would expect one of the nurse 's that were standing here at the nurse 's station to have answered the 2 call bells that were ringing."</p> <p>During an interview on 8/8/13 at 5:23pm the DON stated, "The charge nurse should ensure the nurses answer call bell lights if the aides are busy." She indicated her expectations were that nurses provide needed care to the residents if the aides are assisting other residents. She also indicated it would not be appropriate for a nurse to turn off a resident 's call light, not provide care, and tell the resident their aide would be told they need help.</p> <p>During an interview on 8/9/13 at 12:28 pm, Resident #16's sitter stated, "I have a problem when we ring the call bell and the aide can 't get there, someone will come by, including the nurses, and turn the call bell light off. I will ring it again and this morning they turned it off again. The nurse today pushed the cancel button in the room and said 'I will go find her aide and let her know she needs help going to the bathroom.' She had to wait about 15 minutes for care. * I have known her, many times, to ring the bell and have to wait so long that she had an accident."</p> <p>During an interview with Nurse Aide (NA) #6 on 8/9/13 at 1:20 pm, she stated, "This morning I was assigned to the dining room and was assisting residents with their meals. After the breakfast meal, another aide told me that [Resident #16] ' needs to go to the bathroom and the nurse told me to tell you.' When I asked her</p>	F 241			

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F 241	<p>Continued From page 9</p> <p>why someone had not already helped her to the bathroom, she said, 'you 'll have to ask her nurse about that. ' " NA #6 indicated she then went into Resident #16's room to assist her with toileting and the resident stated she had been waiting about 15 minutes for care.</p> <p>During an interview with the DON on 8/9/13 at 3:21 pm she stated, "The sitters are strictly to sit with them. They are not here to provide care. It is not our expectation for the sitter to provide any care. The staff is expected to provide 100% of the resident care, it is my expectation that staff toilets every resident every 2 hours and does not ignore or turn off call bells without providing care."</p> <p>3. Resident #65 was admitted on 12/1/08 and readmitted on 3/8/13 with diagnoses that included dementia, difficulty walking, lack of coordination, osteoporosis, history of falls, and muscle weakness.</p> <p>The quarterly Minimum Data Set (MDS) dated 6/4/13 indicated the resident was severely cognitively impaired, needed one person physical assist for toileting, was not steady with walking, was only able to stabilize with assistance, and was occasionally incontinent.</p> <p>The care plan updated 6/14/13 indicated the resident "has been continent of bowel and bladder lately with toileting assist. " Interventions included, " Encourage resident to call for assistance with toileting (might try to walk to the bathroom alone), and keep call light within easy reach of resident. "</p> <p>An observation of Resident #65 on 8/8/13 at</p>	F 241			

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F 241	<p>Continued From page 10</p> <p>11:55 am revealed the resident sitting on the side of her bed, with her walker in front of her, holding her call bell in her left hand, and pushing it repeatedly. The resident's call light was on and visible from the hallway. Resident #65 stated, "I really need to go to the bathroom. I rang my bell quite some time ago but no one will come to help me." The resident was distressed, slightly rocking on the edge of the bed, with a worried expression on her face. Nurse Manager #3 entered the room at 12:01 pm and assisted the resident with toileting.</p> <p>During a continuous observation of Resident #65's hallway on 8/8/13 from 4:00 pm - 4:18 pm, call lights for rooms 136 and 137 were observed on in the hallway and were audible from the nurse 's station. Nurse #1, Nurse #2, and Nurse #3 were at the nurse 's station, talking. The DON was also standing at the nurse's station. There were no aides visible in the hallway. When asked whether the aides assigned to the observed hallway were on break or providing care, the DON stated, " When [aides] leave the floor for break [they] report off to the nurse. None are on break right now. They are providing care." When asked about the 2 call lights that had been ringing for 18 minutes she stated, "It is my expectation that nurses answer call bells if the aids are not available. I answer call bells when I am walking the halls and I would expect one of the nurse 's that were standing here at the nurse 's station to have answered the 2 call bells that were ringing."</p> <p>During an interview on 8/8/13 at 5:23pm the DON stated, "The charge nurse should ensure the nurses answer call bell lights if the aides are busy." She indicated her expectations were that nurses provide needed care to the residents if the</p>	F 241			

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F 241	<p>Continued From page 11</p> <p>aides are assisting other residents. She also indicated it would not be appropriate for a nurse to turn off a resident's call light, not provide care, and tell the resident their aide would be told they need help.</p> <p>4. During a continuous observation of Resident #50's hallway on 8/8/13 from 4:00 pm - 4:18 pm, call lights for rooms 136 and 137 were observed on in the hallway and were audible from the nurse 's station. Nurse #1, Nurse #2, and Nurse #3 were at the nurse 's station, talking. The DON was also standing at the nurse 's station. There were no aides visible in the hallway. When asked whether the aides assigned to the observed hallway were on break or providing care, the DON stated, " When [aides] leave the floor for break [they] report off to the nurse. None are on break right now. They are providing care. " When asked about the 2 call lights that had been ringing for 18 minutes she stated, " It is my expectation that nurses answer call bells if the aids are not available. I answer call bells when I am walking the halls and I would expect one of the nurse 's that were standing here at the nurse 's station to have answered the 2 call bells that were ringing. "</p> <p>During an interview on 8/8/13 at 5:23pm the DON stated, " The charge nurse should ensure the nurses answer call bell lights if the aides are busy. " She indicated her expectations were that nurses provide needed care to the residents if the aides are assisting other residents. She also indicated it would not be appropriate for a nurse to turn off a resident 's call light, not provide care, and tell the resident their aide would be told they need help.</p> <p>During an interview with Family Member #3 on</p>	F 241			

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F 241	<p>Continued From page 12</p> <p>8/9/13 at 12:39 pm she indicated the resident was unable to toilet herself. She stated she visits the resident "almost dally" and "staff does not check on her and she will have to wet herself then wait for someone to come clean her. I have been putting up with the odor issue for weeks. I have been in recently and she was wet sitting in her recliner, her bed was made, the urine odor was strong and when the bedspread was pulled back the sheets were still soaked with urine. They had made the bed with it wet. Every time I come to visit I can't just sit and visit. I have to work and work to clean her and feed her." She indicated the resident would never want to be sitting around wet and smelling of urine. Family Member #3 stated she and another family member had both spoken to the Administrator and the DON about Residents #50's care not being provided and smelling strongly of old urine.</p> <p>During an interview with the DON on 8/9/13 at 3:21 pm she stated, "There have been multiple issues. [Resident #50] was taken to an activity with feces on her shoes. [Family Member #3] complained, I took her back to the room and had staff clean her. [Family Member #3] contacted me about wet clothes being put in her closet. I investigated and found wet clothing in her closet. [Family Member #3] has complained about her smelling of urine when she visits." She indicated care should be provided in a timely manner, wet clothing should not be put in the closet, and a resident should not be taken to an activity with feces on her shoes.</p> <p>During an interview on 8/9/13 at 5:00 pm with the Administrator, he stated Resident #50's family, "Had an issue one time when the [family member] came in and said [the resident] smelled of old</p>	F 241			

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F 241	<p>Continued From page 13</p> <p>urine. I took it to the manager and had it addressed."</p> <p>5. Resident # 129 was admitted to the facility on 3/2/11 and readmitted on 8/3/12 with diagnoses that included Alzheimer's, osteoporosis, history of falls, muscle weakness, and dementia.</p> <p>The quarterly MDS dated 5/13/13 indicated the resident was severely cognitively impaired, needed extensive assistance with toileting, and was frequently incontinent of bowel and bladder.</p> <p>During a continuous observation of Resident # 129's hallway on 8/8/13 from 4:00 pm - 4:18 pm, call lights for rooms 136 and 137 were observed on in the hallway and were audible from the nurse's station. Nurse #1, Nurse #2, and Nurse #3 were at the nurse's station, talking. The DON was also standing at the nurse's station. There were no aides visible in the hallway. When asked whether the aides assigned to the observed hallway were on break or providing care, the DON stated, "When [aides] leave the floor for break [they] report off to the nurse. None are on break right now. They are providing care." When asked about the 2 call lights that had been ringing for 18 minutes she stated, "It is my expectation that nurses answer call bells if the aids are not available. I answer call bells when I am walking the halls and I would expect one of the nurse's that were standing here at the nurse's station to have answered the 2 call bells that were ringing."</p> <p>During an interview on 8/8/13 at 4:21 pm with Resident #129's visitor/advocate, she indicated she and the resident's family member visit the resident for about 7 hours each day. She indicated concerns related to insufficient staffing</p>	F 241		

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F 241	<p>Continued From page 14</p> <p>to provide care, call bell lights not being answered, and long waits for toileting. She stated, " There are not enough aides when the lights go off to give the care the residents need. I have to go get them to take her to the bathroom. We push the call bell if she needs to use the bathroom and have had to wait 20 minutes or more. I have spoken to [the DON] about this. The call bell light gets cut off too. I have turned it on before and before someone ever came to help her, the light was turned off. I have gone to the nurse ' s station and there have been call bell lights on in the hallway. There were no aides on the hallway and the nurse ' s were sitting at the station and did not answer the call bells." She indicated the resident was not cognitively intact now but would be "terribly embarrassed if she understood what was going on."</p> <p>During an interview on 8/8/13 at 5:23pm the DON stated, "The charge nurse should ensure the nurses answer call bell lights if the aides are busy." She indicated her expectations were that nurses provide needed care to the residents if the aides are assisting other residents. She also indicated it would not be appropriate for a nurse to turn off a resident's call light, not provide care, and tell the resident their aide would be told they need help.</p> <p>During an interview with the DON on 8/9/13 at 3:21 pm she stated, "The sitters are strictly to sit with them. They are not here to provide care. It is not our expectation for the sitter to provide any care. The staff is expected to provide 100% of the resident care. It is my expectation that staff toilets every resident every 2 hours and does not ignore or turn off call bells without providing care."</p>	F 241			

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F 244 F 244 SS=E	Continued From page 15 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT Is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to act upon concerns raised by the majority of residents attending Resident Council Meetings. Findings Included: The Resident Council Policy dated 11/1997 stated, "The facility will listen to the views and grievances of the group and act upon them. Acting upon them means that serious consideration will be given to requests and attempts made to accommodate requests or explanations given as to why the request cannot be met." Record review of the Resident Council Concerns forms dated 8/24/13 revealed concerns stating, "Residents are falling because their call buttons are not answered soon enough so they try to toilet themselves and fall" and "Sometimes it takes up to an hour to answer call lights and residents end up trying to take themselves to the bathroom, even though they need assistance." The Recreation Services Director noted on the minutes the concerns were sent to the DON and	F 244 F 244	<i>F244</i> 1. The affected residents' current concerns will be reviewed to ensure a response/resolution has been met and communicated. The Administrator and/or designee will complete this review. 2. The past concerns (previous 12 months) from Resident Council meetings will be reviewed to ensure a response/resolution has been met and communicated. The Administrator and/or designee will complete this review monthly.	9/13/13

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F 244	<p>Continued From page 16</p> <p>stated, "After most of the group agreed that this was a problem, I assured them that I would take their concerns to the appropriate manager, DON." There was no follow-up of resident concerns noted on the Resident Council Concern sheets by the DON or any other staff member.</p> <p>During an interview with the Resident Council President, Resident #16, at 8/8/13 at 3:28 pm, she stated, "Residents will bring up concerns during Resident Council Meetings such as call lights not being answered but the issues are not addressed and keep occurring." She indicated that no one from the facility communicates any follow up or investigation of concerns to the Resident Council.</p> <p>During an interview with the DON on 8/9/13 at 3:21pm, she stated, "There is always a staff member in Resident Council meetings that will bring the concerns to me if it is nursing. There should not be any grievances that do not have a resolution." She indicated that the Resident Council Concern sheets dated 8/24/13 did not have any follow up or resolution and that she had not addressed the concerns with the Resident Council.</p> <p>During an interview on 8/9/13 at 5:00 pm with the Administrator, he indicated that grievances or complaints, including Resident Council concerns, should be in writing on a concern form, should indicate the concern, how the concern was handled, and communication to the person, or group, who filed the grievance/complaint. He also indicated the DON was the staff person assigned to handle any grievance related to care. He stated, "I know [the DON] received the resident council form because call bells are</p>	F 244	<p>3. The Administrator and/or designee will in-service Recreational Services staff and Department Heads on the procedure for Resident Council Concerns. The Administrator will receive all Resident Council Concern Forms, distribute to the appropriate Department Head, Department Head to return to Administrator with resolution. The Administrator will review and forward to Recreational Services to communicate at the next Resident Council meeting.</p> <p>4. The Administrator and/or designee will conduct random audits of the Resident Council Grievance Forms to ensure a resolution has been met and communicated to the Resident Council. The results of these audits will be reviewed quarterly during Quality Assurance Meetings.</p> <p>5. September 13, 2013</p>	

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F 244	Continued From page 17 talked about at the staff meetings. I would expect that the form would indicate a response." The Resident Council Concerns forms dated 6/24/13 indicated they were given to the DON and did not indicate any response.	F 244		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 record review, staff interview, and observation the facility failed to provide incontinence checks every 2 hours and failed to provide change in positioning every 2 hours for 1 of 1 residents (Resident #31). Findings Included: Resident #31 was admitted on 8/10/06 with diagnosis including stroke, schizophrenia, and urinary frequency. The most recent Minimum Data Set (MDS) significant change dated 6/02/13 indicated Resident #31 was totally dependant on staff for activities of daily living (ADL), incontinent of bowel and bladder, and moderately cognitively impaired. The care plan dated 6/12/13 indicated Resident #31 was care planned for potential for skin breakdown related to impaired mobility and	F 312	<i>F312</i> 1. The affected resident's care plan was reviewed for accuracy and updated to reflect the interventions of every 2 hours incontinence checks and positioning changes. The Clinical Nurse Manager and/or designee will educate direct care staff on the resident's individual interventions. 2. A monthly sample of 5 current residents with the interventions of 2 hours incontinence checks and positioning changes will be completed. The Clinical Nurse Manager and/or designee will monitor to ensure these residents' care plan interventions are being addressed.	9/20/13

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F 312	<p>Continued From page 18</p> <p>Incontinence, extensive assistance with ADL ' s, dependant for toileting and Incontinent of bladder and bowel with a history of urinary tract infections (UTI) and encourage to attend social groups. Interventions included in part, assist with toileting and pericare, assist to reposition resident on each round, and reinforce attendance at activities events with verbal praise.</p> <p>During an interview with family member #1 on 8/8/13 at 12:06 PM, Family Member #1 stated they have asked staff to check and change Resident #31 every two hours.</p> <p>On 8/9/13 at 10:00 AM, continuous observation of Resident #31 began. At 10:00 AM Resident #31 was noted to be sitting in the hall in front of nurse ' s station East/North in a Broda chair with her feet elevated, asleep.</p> <p>At 10:30 AM, the continuous observation continued. No change in residents ' position or location. No staff members have addressed resident.</p> <p>At 10:48 AM, continuous observation continued. No change in resident ' s position. Resident #31 was not approached.</p> <p>At 11:00 AM, continuous observation continued. No change in residents ' position or location. No staff members had addressed resident.</p> <p>At 11:05 AM, NA#1 and NA#9 passed Resident #31 still sitting in the same position and area. Neither approached Resident #31.</p> <p>At 11:16 AM, continuous observation continued.</p>	F 312	<p>3. Licensed nurses and nurse aide staff will be in-serviced on how to use the care plan information to provide individualized interventions for each resident. The Clinical Nurse Manager and/or designee will monitor to ensure resident's care plan interventions are addressed.</p> <p>4. The Director of Nursing and/or designee will conduct random audits of resident care plans to check for accuracy and for implementation of interventions. The results of these audits will be reviewed quarterly during Quality Assurance Meetings.</p> <p>5. September 20, 2013</p>	

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F 312	<p>Continued From page 19</p> <p>No change in residents ' position or locallon. No staff members had addressed resident.</p> <p>At 11:25 AM, continuous observation continued. No change in residents ' position or location. No staff members had addressed resident.</p> <p>At 11:44 AM, continuous observation continued. No change in residents ' position or location. No staff members had addressed resident.</p> <p>At 11:50 AM, continuous observation continued. A family member came to the nurse ' s station where Resident #31 was and took resident back to her room at the end of the hail. The continuous observation continued.</p> <p>At 12:00 PM, continuous observation continued. No change in residents ' position or location. No staff members had addressed resident. Family member present.</p> <p>At 12:10 PM, continuous observation continued. No change in residents ' position or location. No staff members had addressed resident. Family member present.</p> <p>At 12:25 PM, continuous observation continued. No change in residents ' position or location. No staff members had addressed resident. Family member present.</p> <p>At 12:27 PM, NA #9 came out of a resident ' s room and sat down at the nurse ' s station. NA #9 stated they were waiting for lunch trays and stated they were done getting resident ' s ready for lunch.</p> <p>At 12:30 PM, NA #9 passing trays on the north</p>	F 312			

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F 312	<p>Continued From page 20</p> <p>unit. No change in Resident #31 position or locallon. Resident #31 has not been approached by any staff.</p> <p>At 12:35 PM, Resident #31 was in her room with a family member. No staff had addressed resident or attempted to provide Incontinent care or repositioning since 10:00 AM.</p> <p>At 12:40 PM, lunch trays arived on east unit. NA #1 and NA #9 started passing trays.</p> <p>At 12:45 PM, Family Member #1 went to get Resident #31 ' s lunch tray and brought it back to Resident 31 ' s room. During an interview with NA #9 at this time, NA #9 stated she was caring for Resident #31 and that Resident #31 was changed at " 10:30 AM, because me and NA#1 brought her into the room and took her back down to the nurse ' s station at that time. " She stated that all their rounds had been completed prior to lunch.</p> <p>At 12:50 PM, Resident #31 was changed. An observation of incontinent care indicated Resident #3 was moderately incontinent of urine. Incontinent care was provided. Continuous observallon ended.</p> <p>At 12:55 PM, NA #1 stated Resident #31 was changed " sometime between 10:30 AM and 11:00 AM cause we needed to get the sit to stand because Resident #31 was changed from a lift to a sit to stand. "</p> <p>The DON, during an interview on 8/9/13 at 5:00 PM, stated that her expectations were that each resident was checked every 2 hours and toileted if needed.</p>	F 312			

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F 312	Continued From page 21	F 312		
F 353 SS=E	<p>The Administrator, during an interview on 8/9/13 at 6:30 PM stated he expected the residents would be cared for in a manner appropriate for the care that is required. He stated that waiting over 2 hours for toileting or checking a resident who is incontinent was not acceptable.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, family and resident interviews the facility failed ensure staff were available to provide care for 5</p>	F 353	<p>F353</p> <p>1. The affected residents' care plans have been reviewed for accuracy and updated. The Administrator, Director of Nursing, and/or designee will compare the resident's care plan interventions with the staffing on the particular unit to ensure the resident's needs are met.</p> <p>2. A monthly sample of 10 current residents' care plans will be completed. As part of this sample, the Director of Nursing, Administrator, and/or designee will compare the resident's care plan interventions with staffing on the particular unit to ensure the resident's needs are met.</p>	9/20/13

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F 353	<p>Continued From page 22 of 5 sampled residents. (Residents #189, #65, #16 #129, #50)</p> <p>Findings Included: 1a</p> <p>Resident # 189 was admitted on 5/21/13 with the diagnosis of hypertension, hyperlipidemia, and stroke with left sided paralysis. The current Minimum Data Set (MDS) revealed Resident #189 had no short or long term memory loss and was able to make decisions of her daily care. She required extensive assistance with toileting, bed mobility, dressing, personal hygiene and bathing. She required assistance with balance moving from surface to surface. She also had an impairment of one side of her body (left sided paralysis).</p> <p>Review of care plan dated 6/3/13 revealed Resident #189 had bowel and bladder incontinence and dependence on staff for toileting assistance. Interventions included in part, encourage resident to call for assistance with toileting and to offer toileting assistance on each round.</p> <p>Review of care plan dated 6/3/13 revealed Resident #189 needed extensive to total ADL (activities of daily living) assistance following a stroke with L (left) sided weakness and inattention. Interventions included in part, set-up for ADL and assist as needed (L arm flaccid).</p> <p>Review of facility concern dated 6/30/13, indicated on 6/29/13 Aide #7 refused to provide assistance with dressing and had placed Resident #189 on a bed pan leaving her for an extended period of time.</p>	F 353	<p>3. The Administrator, Director of Nursing, and/or designee will review direct care staffing daily to ensure that resident individualized needs are met.</p> <p>4. The Administrator and/or designee will conduct random surveys of residents and or resident family members. The random survey will monitor to see if residents and/or resident family members feel like the resident's individual needs are being met.</p> <p>5. September 20, 2013</p>	

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F 353	<p>Continued From page 23</p> <p>During an interview on 8/5/13 at 3:20 pm, Resident #189 indicated she was not able to control urination and during the night she used a bedpan. She revealed on 8/29/13 she had been left on the bed pan for hours on the 7pm-7am shift. The incident was reported to the Director of Nursing (DON) the next morning.</p> <p>During an interview on 8/7/13 at 5:00 pm, Aide #7 indicated she was moved off the rehab hall to another hall after an accusation of leaving Resident #189 on the bed pan. She had voiced concern she was unable to provide patient care for eighteen residents. Aide #7 indicated she would be giving care to a resident in one room and the call lights went off for another room. The personal alarms would go off.</p> <p>During an interview on 8/7/13 at 6:16 pm, the Director of Nursing indicated Aide #7, had been accused of not taking Resident #189 off the bed pan and refused to dress her. The facility found Aide #7 negligent in her patient care duties.</p> <p>1b. During an interview on 8/8/13 at 3:15pm, Nurse #1 revealed Aide #2 was assigned to the wash/rehab hall had left at 1:30 pm. The Nurse Manager #3 had changed the aide assignment but was unable to identify which aide was responsible for patient care.</p> <p>During an interview at 1:32pm, Nurse Manager #3 indicated she had not assigned anyone to care for the residents in rooms 145-151 and 140-2 (Rehab hall) until 3:00pm. She expected the nurses to watch the call bells. Aide #1 approached the nursing station and she indicated</p>	F 353		

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F 353	<p>Continued From page 24</p> <p>that Aide # 1 had answered the call bells for Aide #2 residents. Aide #1 indicated he had not provided care for the Aide #2 residents. Nurse Manager #3 indicated an aide should have been assigned to the residents, between 1:30pm and 3:00pm. She had assumed the nurses would answer the call bells.</p> <p>Review of the staff west /rehab assignment sheet for 8/8/13 revealed no staff were assigned for residents in rooms 145-151 and 140-2, between the hours of 1:30 -3:00 pm and they would be short another aide at 3:00 pm.</p> <p>During an interview on 8/8/13 at 4:00 pm, the Director of Nursing indicated her expectation was an aide to be assigned to residents at all times and nurses were expected to provide patient care. The DON indicated Nurse Manager #3 reported to her the mistake she had made. During a telephone interview on 8/9/13 at 10:00am Aide # 5 indicated she was working on 8/8/13 from 7:00 am- 3:00 pm, on the west hall and was not aware Aide #2 had left at 1:30pm. She had not provided care to Aide #2 's residents. She indicated aides do not check the rooms unless they are assigned to the room. She indicated that last week her assignment was twenty residents who were all total care. She revealed providing care for twenty residents was nearly impossible.</p> <p>During a telephone interview on 8/9/13 at 11:10 am, Aide #4 indicated she was working the west/rehab hall on 8/8/13, from 7:00am - 7:00 pm and was not assigned to Aide #2 residents after 1:30 pm. She indicated she was aware Aide #2 had left early and no aide was assigned to the rehab hall until 3:00 pm. She had attempted to provide care for all twenty residents.</p>	F 353			

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F 353	<p>Continued From page 25</p> <p>During an interview on 8/8/13 at 5:10 pm, DON was asked what was her expectation when an aide goes home, she indicated, when an aide goes home sick, the nurse manager would pull from the restorative dept, or the facility would actually, assign someone to the hall from the PRN (as needed) list, or hospital. The nurses were not to "watch the call lights." I would expect the nurse manager to make the assignment. The nurse manager should assign the nurse to take a patient care load and the nurse manager should take the nursing assignment.</p> <p>2. Resident #65 was admitted on 12/1/06 and readmitted on 3/8/13 with diagnoses that included dementia, difficulty walking, lack of coordination, osteoporosis, history of falls, and muscle weakness.</p> <p>The quarterly Minimum Data Set (MDS) dated 6/4/13 indicated the resident was severely cognitively impaired, needed one person physical assist for toileting, was not steady with walking, was only able to stabilize with assistance, and was occasionally incontinent.</p> <p>The care plan updated 6/14/13 indicated the resident "has been continent of bowel and bladder lately with toileting assist." Interventions included encourage resident to call for assistance with toileting (might try to walk to the bathroom alone), and keep call light within easy reach of resident.</p> <p>An observation of Resident #65 on 8/8/13 at 11:55 am revealed the resident sitting on the side of her bed, with her walker in front of her, holding</p>	F 353			

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F 353	<p>Continued From page 26</p> <p>her call bell in her left hand, and pushing it repeatedly. The resident's call light was on and visible from the hallway. Resident #65 stated, "I really need to go to the bathroom. I rang my bell quite some time ago but no one will come to help me." The resident was slightly rocking on the edge of the bed, with a worried expression on her face. Nurse Manager #3 entered the room at 12:01 pm and assisted the resident with toileting.</p> <p>3. Resident #16 was admitted to the facility on 9/9/05 and readmitted on 6/12/12 with diagnoses that included history of falls, muscle weakness, heart failure, hypertension, and osteoporosis.</p> <p>The annual MDS dated 6/3/13 indicated the resident was cognitively intact, required extensive assistance with toileting, was frequently incontinent, and participated in the assessment.</p> <p>The care plan updated 6/17/13 indicated, "Frequent episodes of urinary incontinence. Extensive toileting assist needed." Interventions included assist with incontinence care as needed, encourage resident to call for assistance with toileting, and keep call light within easy reach.</p> <p>During an interview with Resident #16 on 8/8/13 at 3:28 pm she stated, "There is not nearly enough help. I ring the call bell and it is a long, long time before they can get here. The aides are so busy." Resident #16 indicated she has had to "wait over 20 minutes many times" for her call bell to be answered and that nurses would come into her room, turn off the call bell, and tell her they would let her aide know she needed assistance. She indicated she would then have to wait lengthy periods of time before an aide could help her. She stated that she was "forced to wet</p>	F 353			

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F 353	<p>Continued From page 27</p> <p>myself" due to her call bell not being answered and, "I have been put on the toilet and left there so long that I used my phone and called my [Family Member #2] to come to the facility and got me off the toilet." Resident #16 indicated having to wait so long for assistance and having to be incontinent due to waiting made her feel frustrated and feel badly.</p> <p>During an interview on 8/8/13 at 3:45 pm Family Member #2 indicated she visits Resident #16 daily and stated, "On a good day there are only two aides on this hall and the short hall. I have been here when [Resident #16] has pushed her call bell to go to the bathroom and has waited 20 minutes or more. I have requested from the nurses sitting at the nurse 's station, when the aides were all busy, to help her and the response has been, 'Let me find her aide.'</p> <p>During a continuous observation of Resident #16's hallway on 8/8/13 from 4:00 pm - 4:18 pm, the call light for her room and another room were observed on in the hallway and were audible from the nurse's station. Nurse #1, Nurse #2, and Nurse #3 were at the nurse's station, talking. The DON was also standing at the nurse's station. There were no aides visible in the hallway. When asked whether the aides assigned to the observed hallway were on break or providing care, the DON stated, "When [aides] leave the floor for break [they] report off to the nurse. None are on break right now. They are providing care." When asked about the 2 call lights that had been ringing for 18 minutes she stated, "It is my expectation that nurses answer call bells if the aids are not available. I answer call bells when I am walking the halls and I would expect one of the nurses that were standing here at the nurse's</p>	F 353			

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F 353	<p>Continued From page 28</p> <p>station to have answered the 2 call bells that were ringing."</p> <p>During an interview on 8/8/13 at 5:23pm the DON stated, "The charge nurse should ensure the nurses answer call bell lights if the aides are busy."</p> <p>During an interview on 8/9/13 at 12:28 pm, Resident #16's silter stated, "I have a problem when we ring the call bell and the aide can't get there, someone will come by, including the nurses, and turn the call bell light off. I will ring it again and this morning they turned it off again. The nurse today pushed the cancel button in the room and said 'I will go find her aide and let her know she needs help going to the bathroom.' She had to wait about 15 minutes for care." I have known her, many times, to ring the bell and have to wait so long that she had an accident."</p> <p>During an interview with Nurse Aide (NA) #6 on 8/9/13 at 1:20 pm, she stated, "This morning I was assigned to the dining room and was assisting residents with their meals. After the breakfast meal, another aide told me that [Resident #16] 'needs to go to the bathroom and the nurse told me to tell you.' When I asked her why someone had not already helped her to the bathroom, she said, 'you'll have to ask her nurse about that.'" NA #6 indicated she went into Resident #16's room to assist her with toileting and the resident stated she had been waiting about 15 minutes for care.</p> <p>During an interview on 8/9/13 at 3:21 pm the DON stated, "I have received concerns from [Resident #16's family members] about not having enough staff." Regarding silters providing</p>	F 353			

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F 353	<p>Continued From page 29</p> <p>care she stated, "The sitters are strictly to sit with them. They are not here to provide care. It is not our expectation for the sitter to provide any care. The staff is expected to provide 100% of the resident care. It is my expectation that staff toilets every resident every 2 hours and does not ignore or turn off call bells without providing care."</p> <p>4. Resident # 129 was admitted to the facility on 3/2/11 and readmitted on 8/3/12 with diagnoses that included Alzheimers, osteoporosis, history of falls, muscle weakness, and dementia.</p> <p>The quarterly MDS dated 5/13/13 indicated the resident was severely cognitively impaired, needed extensive assistance with toileting, and was frequently incontinent of bowel and bladder.</p> <p>During an interview on 8/8/13 4:21 pm with Resident #129's visitor/advocate, she indicated she and the resident's family member visit the resident for about 7 hours each day. She indicated concerns related to insufficient staffing to provide care, call bell lights not being answered, and long waits for toileting. She stated, "There are not enough aides when the lights go off to give the care the residents need. I have to go get them to take her to the bathroom. We push the call bell if she needs to use the bathroom and have had to wait 20 minutes or more. I have spoken to [the DON] about this. The call bell light gets cut off too. I have turned it on before and before someone ever came to help her, the light was turned off. I have gone to the nurse's station and there have been call bell lights on in the hallway. There were no aides on the hallway." She indicated the resident was not cognitively intact now, could use the toilet if staff</p>	F 353			

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F 353	Continued From page 30 assisted her when called, but would be "terribly embarrassed" if she understood that she was incontinent and sitting in her wheelchair unchanged. 5. During an interview with Resident #50's family member, Family Member #3, on 8/9/13 at 12:39 pm she indicated the resident was unable to toilet herself. She stated she visits the resident "almost daily" and "staff does not check on her and she will have to wet herself then wait for someone to come clean her. I have been putting up with the odor issue for weeks. I have been in recently and she was wet sitting in her recliner. Every time I come to visit I can't just sit and visit. I have to work and work to clean her and feed her." She indicated the resident would never want to be sitting around wet and smelling of urine. Family Member #3 stated she and another family member had both spoken to the Administrator and the DON about Residents #50's care not being provided and smelling strongly of old urine.	F 353		
F 441 SS+E	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,	F 441	F 441 1. All resident with current infections will be documented and tracked on a unit specific color-coded map.	9/9/13

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F 441	<p>Continued From page 31</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to Infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to 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 record review and staff interviews the facility failed to maintain an infection control log and failed to investigate infections.</p> <p>Findings Included:</p> <p>The facility provided a copy of their infection control policy that stated " The facility will establish a means of investigation, controlling, and preventing infections in the facility" . The policy was dated February 2007.</p>	F 441	<p>2. All residents (with or without) an active infection will benefit from the structured infection control program. The structured program will entail unit specific color-coded maps that outline various infections actively present in the facility. The Clinical Nurse Manager and/or designee will be responsible for the monitoring/tracking of infections on each unit.</p> <p>3. The Director of Nursing and/or designee will ensure that each unit of the facility has a color-coded map outlining active infections. This program is designed to investigate, control, and prevent infections in the facility.</p> <p>4. The infection control reports will be reviewed quarterly during Quality Assurance Meetings. The information will be used to identify trends/patterns within the facility.</p> <p>5. September 9, 2013</p>		

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F 441	<p>Continued From page 32</p> <p>Review of the documentation revealed the facility had not had an infection control program in place prior to May 26, 2013. The documentation showed for the time period of May 25- June 26, 2013 the facility started documenting infections by use of a log that was only available for rooms 102-1, 105-2, 107-2, 111-2, 116-2, and 126-1 which were all located on the South hall of the facility. A color coded map for each unit was implemented on June 26, 2013. This map showed South Hall, East Hall, North Hall, and West Hall. The color coding was noted to be pink for urinary tract infections (UTI), blue for pneumonia, orange for upper respiratory infection, yellow for wound infection, and green for other.</p> <p>When the log for each resident was reviewed for each hall, there were infections that were noted to be logged but not carried over to the color coded map of each hall.</p> <p>During an interview on 8/9/13 at 2:00 PM, Nurse Manager #1 stated she had only been there for 4 weeks and was in the process of putting in place an infection control log to track the infections on the unit so she could monitor the patterns. She stated this was a new process for the whole facility.</p> <p>During an interview on 8/9/13 at 5:00 PM, when the DON was asked who her infection control nurse was she stated " I guess I am " and then stated she did not have a dedicated infection control person within the facility. The DON stated she had been trying to get her unit managers to implement an infection tracker program that would follow trends in infections, types and strains, and medications used to treat these</p>	F 441			

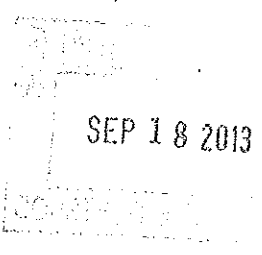
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/09/2013
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY EDEN, NC 27288		
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F 441	Continued From page 33 Infections if they are re-occurring. During an interview on 8/9/13 at 6:30 PM, the Administrator stated that his expectation was that they would be able to track infections and monitor trends that were occurring on the units and help the resident's be infection free or at least decrease the incidence of infections.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED 09/04/2013
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY EDEN, NC 27288	
(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 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 construction, one story, with a complete automatic sprinkler system.	K 000		
K 021 SS=D	The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/4/13 at approximately noon the following fire door was non-compliant specific	K 021	 K 021 1. The door that did not close completely upon activation of the fire alarm system was repaired and now closes properly. 2. Ensure fire doors close properly during monthly fire drills and preventative maintenance. 3. We currently have a fire door preventative maintenance which is scheduled quarterly. The PM was completed on 8/27/13. 4. Continue to monitor during fire drills and preventative maintenance. 5. Corrective action was completed on September 4, 2013.	9/4/13

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

TITLE

(X6) DATE

Michael D. Good Administrator

9/17/2013

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.

DRW

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K 021	Continued From page 1	K 021		
K 038 SS=D	findings include, fire door to room 140 did not close and latch tightly in it's frame. 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	<i>K 038</i> 1. The door hardware will be changed to type with on range of motion to exit. 2. Mechanic assigned to MNC will inspect all locking doors to ensure only one range of motion door hardware is installed.	10/1/13
K 072 SS=D	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/4/13 at approximately noon the following exit access was non-compliant specific findings include, door exiting the billing office, room 112, to the exit corridor had a dead bolt that required more than one range of motion to exit the area. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	3. Training will be completed with mechanics who install door hardware to ensure all future installations include only one range of motion hardware. 4. Director of Facilities will review all requests for door hardware and discuss with mechanics prior to installation. 5. October 1, 2013	
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/4/13 at approximately noon the following means of egress was non-compliant specific findings include, storage of several large moving racks of plate warmers in the corridor			

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K 072	Continued From page 2 near the dishwasher room. This item was corrected on site.	K 072	<p><i>K 072</i></p> <ol style="list-style-type: none"> 1. The rack of plate warmers in the corridor were removed when brought to the facility's attention by the surveyor. 2. The Administrator and/or designed will round the facility to identify if other life safety issues having potential to affect residents by the same deficient practice are present. If there are any present, they will be corrected immediately. 3. The Dietary Assistant Director and/or designee will check daily to ensure that the back corridor of the facility is free of all obstructions or impediments to full instant use in the case of fire or other emergency. 4. The Dietary Assistant Director and/or designee will forward results of daily rounds to Administrator. Results of the daily rounds will be reviewed quarterly at Quality Assurance meeting. 5. September 20, 2013 	9/20/13