

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

SEP 25 2013

PRINTED: 09/05/2013
FORM APPROVED
OMB NO. 0938-0391

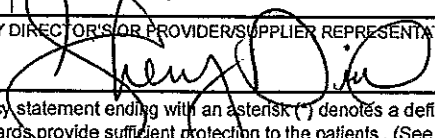
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2013
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NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assess 1 (Resident #22) of 1 resident with a restraint for the least restrictive restraint device.</p> <p>The findings included:</p> <p>Resident #22 was admitted to the facility on 2/27/09 and readmitted 8/29/11. Diagnoses included encephalopathy, presenile dementia, dementia with behavioral symptoms and lack of coordination.</p> <p>The annual Minimum Data Set (MDS) dated 12/28/13 indicated Resident #22 had memory problems, severe cognitive impairment, required extensive assistance of 2 people for transfers, was non-ambulatory, had 1 fall since the last assessment and used a restraint daily while out of bed.</p> <p>The Care Area Assessment (CAA) summary for physical restraints dated 1/8/13 read, "Resident in Broda chair with thigh belts to prevent getting up unassisted and sliding out of chair. He has had one fall from bed since the last review period."</p> <p>The most recent MDS, a quarterly assessment dated 6/28/13, indicated Resident #22 had</p>	F 221	<p>F221</p> <p>1. For resident #22, a restraint reduction assessment was completed by the minimum data set nurse on 8/28/13, to ensure a least restrictive device. Therapy orders obtained for resident #22 on 8/28/13, to attempt a restraint reduction.</p> <p>2. Resident #22 is the only resident in the facility with a restraint. No other residents are identified with the potential to be affected.</p> <p>3. The Director of Clinical Services and or Unit Manager, provided in servicing, to the nursing staff on 9/18/13, regarding regulatory requirements for utilization of a restraint, to include utilization of the least restrictive device. The Director of Clinical Services and or Unit Manager, will utilize a QI audit tool to review residents, with restraint weekly x 4 weeks. Then monthly x 2 months, then quarterly for continued use of a least restrictive device. This review will include trends and need for further education and / or monitoring , as well as revisions required to sustain substantial compliance.</p>	September 19, 2013
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Executive Director

(X6) DATE

9/20/13

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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>memory problems, severe cognitive impairment, required extensive assistance of 1 person for transfers, was non-ambulatory, had 2 falls since the last assessment and used a restraint daily while out of bed.</p> <p>The care plan updated 7/11/13 included a problem of restraint due to history of falls related to unassisted transfers related to dementia. The restraint included a Broda chair with padded thigh straps. The goal was for no adverse effects or injury related to use of the thigh straps. Approaches included Broda chair with thigh belts when out of bed, anti-tippers to Broda chair, release restraint when appropriate during meals and activities while monitoring, evaluate restraint use and reduction quarterly.</p> <p>Review of incident reports and nurse's notes revealed falls on 6/8/13, 7/16, 8/4/13 and 8/20/13, all from the bed to mat or floor. No injuries were sustained.</p> <p>Record review revealed a consent signed by the responsible party on 3/30/09 for a Broda chair with thigh straps. The medical symptoms listed on the form were lack of coordination, poor balance and decreased cognition.</p> <p>Review of August 2013 physician orders revealed "Broda chair with padded thigh belt while out of bed d/t (due to) poor safety awareness, balance and decreased cog (cognition)."</p> <p>Nurse's Notes dated 7/12/13 at 2:15 PM read, "Restraint mtg (meeting): Rsd (resident) continues with thigh straps restraint to Broda chair. Attempt made at this time to reduce. Rsd noted leaning forward while sleeping in chair.</p>	F 221	<p>4. The Director of Clinical Services and or Unit Manager will report the results of the QI monitoring tools to the Quality Assurance committee monthly X 3 months to identify trends and need for further Education and/ or monitoring, as well as revisions required, to sustain substantial compliance.</p>	
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F 221	<p>Continued From page 2</p> <p>Reduction attempt failed. Will make attempt to reduce at a later date."</p> <p>Nurse's Notes dated 8/16/13 at 11:45 AM: "Restraint mtg: Continues to have thigh belt restraints. Attempts made to remove. Pt (patient) continues to lean forward. Unable to remain erect in chair. Continue POC (plan of care)."</p> <p>On 8/21/13 at 9:50 AM and 10:50 AM, Resident #22 was observed in the hall in the Broda chair wearing thigh straps. The resident was asleep and leaning forward. At 4:45 PM the resident was observed awake at the nurses' station sitting up straight and quietly in the Broda chair with thigh straps on.</p> <p>On 8/22/13 at 8:05 AM, Resident #22 was observed in the hall in the Broda chair wearing thigh straps. He was asleep and leaning forward.</p> <p>During an interview on 8/22/13 at 2:10 PM, NA #1 indicated that the resident leans way forward in the gerichair. NA #1 stated that the thigh straps were used because the resident leans so far forward.</p> <p>During an interview on 8/22/13 at 2:10 PM the MDS Nurse indicated she had been with the facility for two and one-half years and Resident #22 had used a Broda chair and thigh straps consistently. The MDS Nurse stated that she performed quarterly restraint reduction assessments which consisted of observing the resident with the restraint on and then off for 30 minutes. The MDS Nurse said no other interventions were attempted during assessment observations. The MDS Nurse added that the medical reason for the restraint was cognitive</p>	F 221			

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F 221	Continued From page 3 impairment with poor safety awareness.	F 221			
F 244 SS=B	<p>During an interview on 8/22/13 at 3:09 PM, Administrative Staff #1 stated that for Resident #22, thigh straps were removed for the observation period. Other interventions were not attempted during the observation period.</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Resident interviews and review of the Resident Council minutes, the facility failed to resolve group grievances regarding noise level and snacks. The findings included:</p> <p>On 2/25/13, a review of Resident Council Minutes revealed residents on B, D, E and F halls had complaints that one resident was too loud. They also indicated they would like to see more of a variety of snacks in the snack room and on the snack cart in the evenings. It was noted that the minutes were distributed to the executive director and appropriate department supervisors for follow-up. No follow up on the complaints and concerns was noted.</p> <p>On 3/18/13, a review of Resident Council Minutes revealed the noise level was better on A, B and D</p>	F 244	<p>F244</p> <p>September 19, 2013</p> <p>1. Resident Council meeting was held by Social Services Director and or Director of Clinical Services on 9/17/13, to communicate process change for follow up on grievances. The facility protocol change includes each grievance form to be initiated by the staff receiving the concern. Each form shall then be directed to the appropriate department for review. Upon receipt, the department manager will create a written plan, to act on each, grievance this will allow staff communication and follow up from the appropriate department in acting on a solution for the concern, to ensure that the right department receives the concern. The appropriate department will then follow up with the resident(s)/family regarding the plan of action. Follow up communication with resolution shall take place in 5 days. Grievances will then be forwarded to social services /administrator for final review and file. Sound level and snacks addressed.</p>		

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F 244	<p>Continued From page 4</p> <p>halls. E hall residents stated there were too many televisions and radios turned on and turned up and too many residents yelling. Residents stated there was still no variety with the snacks for the snack cart. The dietary person was present and stated food items had been ordered and the following items should be on the snack cart soon—gold fish, oatmeal creme pies, moon pies, cookies, cheese crackers. It was noted that the minutes were distributed to the executive director and appropriate department supervisors for follow-up. No follow up on the complaints and concerns was noted.</p> <p>On 4/19/13, a review of Resident Council Minutes indicated residents on E hall said the noise level was terrible. They indicated the noise was coming from both residents and staff. Residents indicated there was more variety on snacks. Residents on E hall stated the only time snacks were offered was when a particular nursing assistant was working. It was noted that the minutes were distributed to the executive director and appropriate department supervisors for follow-up. No follow up on the complaints and concerns was noted.</p> <p>On 5/24/13, a review of Resident Council Minutes revealed residents on D hall said the noise level continued and, at times, they could hear other residents hollering and cursing. All residents in attendance said the noise level was from other residents and not staff. Residents on F hall stated the snacks were great. Residents on E hall stated they were provided snacks for two nights and then snacks were no longer offered. The new Resident Council Minutes form did not note if minutes were distributed to the executive director and appropriate department supervisors</p>	F 244	<p>2. All Residents residing in facility with concerns regarding snacks and noise levels have a potential To be affected.</p> <p>3. Executive Director and or Social Services Director will provide a complete education to interdisciplinary team on 9/16/13 regarding revised grievance protocols. Members of the interdisciplinary team include administrator, director of clinical services, human resources coordinator, business office manager, social worker, house keeping supervisor, dietary manager, medical records manager, central supply manager and rehabilitation director. The Social Services Director and or Activities assistant, will utilize an audit tool To track all grievances, to ensure they have been followed up on 5xweek X 4 weeks, then once a week X 2 months.</p> <p>4. Each QI audit tool will be forwarded to the Quality Assurance Committee by the social services director and or activities assistant once a month X 3 months, as well as revisions required to sustain substantial compliance.</p>		

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F 244	<p>Continued From page 5 or if there was any follow-up on concerns/ complaints.</p> <p>On 6/17/13, a review of Resident Council Minutes revealed that residents on E hall stated the noise level was horrible. Smokers agreed and said they could hear residents yelling out/ cursing when they went outside to smoke. All residents in attendance agreed the noise was caused by residents and not staff. Residents stated no daytime snacks were being offered. F hall stated second shift was the only shift to give out snacks. Residents were informed about the nourishment room on E hall where snacks were available. One resident on E hall stated there were no snacks available on 6/16/13.</p> <p>A Concern form dated 6/17/13 indicated the following action in response to the Resident Council concerns was taken: The concerns regarding snacks were discussed with the dietary manager and daytime snacks would be passed out at 10:00AM. and 2:00PM. as well as 8:00PM. This started at 2:00PM. on 6/17/13. Follow-up conducted on 6/17/13 indicated the daytime snacks were being passed out.</p> <p>On 7/22/13, a review of Resident Council Minutes indicated all residents agreed that the noise level was an ongoing issue. The social worker was present and stated that a psychiatric group was getting started, residents had been identified and the noise level should calm down over the next couple of weeks. The D hall residents stated no snacks were being offered. A hall stated there were very few choices/ amount of snacks in the evening. The social worker reminded the residents about the nourishment room on E hall and residents responded there were few snacks</p>	F 244			

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F 244	<p>Continued From page 6</p> <p>in there and the room was not wheelchair accessible.</p> <p>A Concern form was written on 7/22/13 and indicated the following actions were taken in response to the Resident Council concerns. The dietary staff was made aware of residents' desire for more variety in snacks and to make sure nourishment room stocked. Residents were also informed that a psychiatric group was getting started with residents with disruptive behaviors.</p> <p>On 8/15/13, a review of Resident Council Minutes indicated there continued to be certain residents who were yelling and cursing. A hall residents stated the noise level was worse. E hall residents stated the noise level was better. Residents were informed that psychiatric services were helping with the noise level and the noise level should get better. C hall residents stated first shift forgot C hall when snacks were given out. All residents agreed that residents sometimes did not get snacks left in their room. All residents agreed that second shift gave out snacks.</p> <p>A Concern form written 8/15/13 indicated all staff was in-serviced on 8/19/13 regarding redirecting disruptive residents.</p> <p>On 8/19/13at 6:20 PM., residents were observed sitting around the central nursing station and on the adjoining halls. Resident #40, an unknown female resident and Resident # 38 were making loud noises—screaming, yelling and making loud throat noises as if they were clearing their throat and spitting.</p> <p>On 8/20/13, observations conducted in the main dining room from 8:30AM. To 9:00 AM. revealed</p>	F 244			

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F 244	<p>Continued From page 7</p> <p>same loud noises-screaming, yelling, making loud throat noises.</p> <p>On 8/20/13 at 6:15 PM., when leaving the facility, residents could be heard screaming and yelling from the parking lot area.</p> <p>On 8/21/13 at 9:33 AM., Resident #64 stated the activity coordinator said she spoke to someone about the concerns raised at Resident Council meeting but no one came back and informed the residents about what was done regarding the concerns raised at the Resident Council meetings.</p> <p>On 8/21/13 3:11 PM., Administrative staff #2 stated anytime there was a concern spoken in Resident Council, a Concern form was filled out by the social worker or activity director within twenty four hours. The Concern form was given to the appropriate department personnel and, if it was a general concern, residents would be informed at the next Resident Council meeting.</p> <p>On 8/22/13 from 8:00AM. to 9:00AM, Resident #40 was in the dining room loudly yelling "Hey,hey,hey" repeatedly.</p> <p>On 8/22/13 at 8:11 AM., Administrative staff #4 stated she recorded the minutes at the Resident Council meetings. She said she made copies of the Resident Council minutes and gave copies of the minutes to the Administrator and Director of Nursing. Administrative staff #4 stated she filled out one concern form for all departments. A lot of the time, the action taken and follow-up was verbal and not written. She said she did not know if each department tracked or flowed up on their action plan regarding the Resident council</p>	F 244			

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F 244	Continued From page 8 concerns. On 8/22/13 at 8:30 AM., Administrative staff #4 stated the noise level had increased since February. In February, concerns were voiced about two to three residents who liked to yell and complaints about loud televisions. She said more residents have been admitted with disruptive behaviors and the noise level had increased. On 8/22/13 at 10:00AM., Administrative staff #1 stated the facility had recently begun psychiatric consult services in July 2013 and hoped that this would aid the facility in reducing the disruptive behaviors of residents who displayed those behaviors; therefore the noise level would also decrease.	F 244			
F 257 SS=B	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to maintain a comfortable climate in one of one dining rooms. The findings included: Resident #40 was admitted to the facility on 3/4/13 with the following diagnoses: dementia and anemia. On a quarterly Minimum Data Set (MDS) assessment, dated 7/29/13 she was evaluated to	F 257	F257 September 19, 2013 1. Thermostat in dining room was adjusted to 74 degrees F during survey. 2. Thermostats throughout the facility, were audited by maintenance personnel and adjusted by maintenance personnel, to fall within federal requirements of 71-81 degrees F. 3. Executive Director and or Director of Clinical Services will provided education to key holder Of thermostat boxes on 9/16/13, regarding state and federal regulations regarding temperature ranges. Multiple key holders include administrator, housekeeping supervisor and maintenance personnel. Maintenance personnel and or housekeeping supervisor will utilize a QI monitoring tool to		

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F 257	<p>Continued From page 9</p> <p>be cognitively impaired but capable of making her wants understood by others.</p> <p>On 8/20/13, from 8:00 to 9:00 am, breakfast activities in the main dining room were observed. Resident #40, upon entry, was covered from her shoulders to her feet in a white blanket as she sat in the wheelchair. She was observed to repeatedly call out to staff that she was cold with no response from staff.</p> <p>On 8/21/13, from 12:15 to 12:45 pm, Resident #40 was observed in the dining room sitting at the table covered from her shoulders to her feet in a white blanket. Another woman, an unsampled resident, sat at the table covered in blankets. Resident #40 repeatedly vocalized that she was cold with no response from staff feeding residents.</p> <p>At another table, an unsampled male resident, dressed in summer clothes, voiced that he was cold as well as he sat a long table where staff assisted residents with feeding.</p> <p>The thermostat in the dining room was examined at 12:35 pm, and read 70 degrees. The room was cold and drafty. The D hallway temperature, outside of the dining room, was observed and read 72 degrees, as well as other hallways in the building.</p> <p>Administrative Staff #3 was interviewed on 8/21/13 at 12:40 pm. He stated that he was working part time in the facility and was not contacted by staff that residents were cold in the dining room. He entered the dining room and stated that he turned up the thermostat to 74 degrees which cut off the fan and blower.</p>	F 257	<p>monitor Thermostats throughout facility 3x week X 4 weeks, Then monthly X 2.</p> <p>4. Maintenance personnel and or housekeeping supervisor will forward the results of the QI monitoring tools to the Quality Assurance Committee monthly X 3 months, as well as Revisions required to sustain substantial compliance.</p>	
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F 257	<p>Continued From page 10</p> <p>Upon return to the dining room at 12:45 pm, the air was noticeably warmer and no more complaints about being cold were heard from the residents present.</p> <p>On 8/21/13 at 12:50 pm, Nurse Aids #5 was interviewed as she worked in the dining room. She stated that the dining room was normally kept cool and that some residents, particularly Resident #40 and the unsampled woman, always voiced that they were cold. She mentioned that sometimes she would ask for a technician in the maintenance department to adjust the temperature but today she didn't.</p> <p>On 8/21/13 at 12:54 pm, Nurse Aide #2 was interviewed as she worked in the dining room. She stated that some residents complain year round about the air being too cold in the dining room but she always felt it was comfortable.</p> <p>On 8/22/13 at 8:30 am, the thermostat was observed in the dining room. It read 74 degrees. The climate was warmer then the hallways. Resident #40 and an unsampled woman, sat at the table with a blanket across their laps, but never complained out loud about being cold.</p> <p>On 8/22/13 at 9:40 am, Resident #67 was interviewed. She was alert and oriented and stated that she came to the dining room to participate in activities, but always had to bring a sweater to wear because the room was too cold for her.</p> <p>Administrative Staff #2 was interviewed on 8/22/13 at 3:45 pm. She commented that state regulations instruct facilities to maintain the</p>	F 257		
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F 257	Continued From page 11 temperature between 72-81 degrees. Yesterday, administrative staff #3 brought to her attention that the air in the dining room was set at 70 degrees. She stated that she instructed him to make sure that all of the thermostats in the building were in the range (72-81 degrees). Further, he would add labels to the thermostats indicating the desired temperature goals. Until yesterday, she stated that she was unaware that residents had complained about being too cold.	F 257			
F 258 SS=B	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to maintain comfortable sound levels. The findings included: On 8/19/13 at 6:15 pm, a modest group of residents were observed situated around the nurse's station in their wheelchairs, with several of the ladies making loud noises, yelling, repeatedly throat clearing and then spitting. No verbal redirection was observed by staff. On 8/20/13 between 8:30 to 9:00 am, Resident #40 was observed sitting at a table with two other females, constantly yelling out to staff that she wanted toast and that she was cold. Staff was unable to redirect her successfully. During this	F 258	F258 1. A medication regimen review was be completed by a licensed pharmacist consultant on 9/18/13, for resident #38 and #40. 2. All residents residing in the facility have the potential To be affected. Interviews of inter viewable residents have been conducted and completed by Social Service Director and or activities assistant, on 9/12/13 regarding noise levels. 3. Director of Clinical Services and or unit manager will provide education to nursing staff, regarding comfortable sound levels and redirection techniques. Education will be completed on 9/18/13. The Social Services Director and or director of clinical services and or activities assistant will utilize QI monitoring tools to document responses of inter viewable residents, regarding	September 19, 2013	

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F 258	<p>Continued From page 12</p> <p>meal, Resident #38 was observed to sit at a table with two other women and loudly clear her throat, then spit in a cup, repeatedly, throughout the meal. No staff was observed redirecting her.</p> <p>On 8/20/13 at 6:15 pm, loud noises from residents hollering could be heard from the parking lot outside of the facility.</p> <p>A record review was conducted of the Resident Council Minutes from 2/25/13 until 8/15/13. Each month, alert and oriented residents in attendance would complain about loud noises coming from some residents and/or from televisions and radios, allowed to play loudly in rooms at night. Residents stated that they were bothered by some of the residents, yelling, hollering and cursing.</p> <p>Under "Old Business" the minutes from the 6/17/13 recorded that residents on the E hall stated that the noise level was horrible. Residents who were required to smoke outdoors, behind the building, were recorded to say that they can hear the residents hollering and cussing while they are outside.</p> <p>The minutes reflected that the residents attending the council meetings were told, that the addition of psychiatric supports getting started in July 2013, servicing some residents, would improve some of the disruptive behaviors.</p> <p>On 8/21/13 from 12:15 to 12:45 pm, Resident #40 was observed to yell out repeatedly in the dining that she was cold and displayed other disruptive behaviors.</p> <p>During breakfast on 8/22/13 from 8:00 to 9:00</p>	F 258	<p>facility sound Levels, once a week X 4 weeks, once a month X 2.</p> <p>4. Social Services Director and or Activities Assistant will forward the results of the QI tools to the Quality Assurance Committee monthly X 3, As well as revisions required to sustain substantial compliance.</p>		

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F 258	<p>Continued From page 13</p> <p>am, Resident #40 could be heard yelling "Hey, Hey, Hey" repeatedly while she sat in the dining room then in the hallway, at the nurse's station. Staff was not heard, redirecting her.</p> <p>On 8/22/13 at 9:45 am, Resident #67 stated that she found the noise from a resident on the A hall to be disturbing.</p> <p>On 8/22/13 at 11:55 am, Resident #64 was interviewed. She stated that B hallway was noisy, but she didn't feel that she could close her door to block out the noise, because it made her room too hot. She then identified Resident #40, by pointing her finger at her, as someone who was too loud.</p> <p>On 8/22/13 at 8:30 am Administrative Staff #4 was interviewed. She shared that her staff has tried to engage some of the residents with disruptive behaviors in activities and at times they were able to calm them down. However, she stated that the noise level has increased since February, 2013. She shared that originally there were about 2 to 3 residents who liked to yell but now there have been more residents admitted with issues like yelling and she was hopeful that the psychiatric supports would help.</p> <p>On 8/22/13 at 3:00 pm, the Administrative Staff #1 was interviewed. She stated that noise has been a problem at the facility and it mostly became an issue in the late afternoons and evening hours. She shared that the facility now has psychiatric services evaluating some of the residents, which have decreased some of the noise and incidents that used to escalate behaviors. Staff have been given ideas how to address the behaviors more successfully, as well</p>	F 258			

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F 258	Continued From page 14 as trying new interventions. On 8/22/13 at 3:50 pm, Administrative Staff #2 was interviewed about problems with noise. She stated that the facility had a new contract for psychiatric support systems as well as a psychologist to look at non-pharmacological resources to help some of their residents with behaviors that are disruptive to others.	F 258			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to address in care plan the use of	F 279	F279 1. Resident #8, Care plan was revised on 8/21/13, by the minimum data set nurse, to include utilization of the antidepressant medication and swallowing problem. 2. For residents currently residing in facility, physician orders for antidepressants were reviewed by the minimum data set nurse on 8/21/13. Residents with swallowing problems were reviewed by the minimum data set nurse and the dietary manager on 9/17/13. No other residents were identified. The minimum data set nurse updated the care plans on 9/17/13. 3. The Director of Clinical Services and or Unit Manager completed education with minimum data set nurse on 9/17/13, regarding Revisions of care plans,	September 19, 2013	

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F 279	<p>Continued From page 15</p> <p>antidepressant medication and the swallowing problem for 1 (Resident #8) of 5 sampled residents. Findings included:</p> <p>1 a. Resident #8 was admitted to the facility on 3/13/13 with multiple diagnoses including Depression, Hypertension and Edema. The quarterly MDS assessment dated 7/16/13 indicated that Resident #8 had memory and decision making problem. The assessment also indicated that Resident #8 had not received antidepressant medication.</p> <p>The doctor's orders were reviewed. On 7/4/13, there was an order for Lexapro (antidepressant drug) 5 mgs (milligram) daily for depression and on 8/6/13, Lexapro was increased to 10 mgs daily from 5 mgs.</p> <p>The Medication Administration Record (MAR) for July, 2013 was reviewed. The MAR indicated that Resident #8 had received the Lexapro as ordered.</p> <p>The care plan dated 7/18/13 (review date) was reviewed. The use of the antidepressant medication was not addressed in the care plan.</p> <p>On 8/21/13 at 4:05 PM, the MDS Nurse was interviewed. The MDS assessment and the MAR were reviewed and she acknowledged that she had missed to code the use of antidepressant. She also added that because she missed to code the antidepressant on the MDS, she also had missed to address it on the care plan. She further indicated that she would add it on the care plan today.</p> <p>1b. Resident #8 was admitted to the facility on</p>	F 279	<p>to include antidepressant medications ,And swallowing problems. New residents will be identified by reviewing physicians' orders. The minimum data set nurse will review orders. The minimum data set nurse and or unit manager will utilize a QI monitoring tool, during review of care plan for residents with physicians' orders of antidepressants and or swallowing Problems to ensure that care plans include these orders. 5xweekX 4 weeks, 3xweek X 8 weeks.</p> <p>4. The Director of Clinical Services and or minimum data set nurse will forward The results of the QI tools to the Quality assurance Committee monthly X 3, as well as revisions required to sustain substantial compliance.</p>		

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F 279	Continued From page 16 3/13/13 with multiple diagnoses including Depression, Hypertension and Edema. The quarterly MDS assessment dated 7/16/13 indicated that Resident #8 had memory and decision making problem. On 7/11/13, there was a doctor's order to change the texture of the diet to puree. On 8/9/13, there was a clarification order for "ST (speech therapy) 5 times per week for dysphagia and symbolic dysfunction, may include dysphagia therapy and cognitive -linguistic therapy." On 8/14/13, there was a doctor's order to change to nectar thick liquids. The care plan dated 7/18/13 (review date) was reviewed. The swallowing problem and the special diet (puree with nectar thick liquids) were not addressed in the care plan. On 8/21/13 at 12:40 PM and 8/22/13 at 8:25 AM, Resident #8 was observed receiving thin liquids (juice and milk). On 8/21/13 at 4:05 PM, the MDS Nurse was interviewed. She stated that she was supposed to address swallowing problem and the need for thickened liquids in the care plan. She added that she was not aware that the diet for Resident #8 was changed to puree with nectar thick liquids.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		September 19, 2013	

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F 309	<p>Continued From page 17</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the diuretic medication was administered as ordered for 1 (Resident #8) of 5 sampled residents. Finding included:</p> <p>Resident #8 was admitted to the facility on 3/13/13 with multiple diagnoses including Depression, Hypertension and Edema. The quarterly MDS assessment dated 7/16/13 indicated that Resident #8 had memory and decision making problem.</p> <p>Review of the care plan dated 7/18/13 (review date) revealed that the use of the diuretic and the edema was not addressed in the care plan.</p> <p>The doctor's orders were reviewed. On 5/24/14, there was a doctor's order for Bumex (diuretic) 0.5 mgs (milligram) daily for edema. On 7/8/13, Bumex was discontinued. On 8/6/13, there was an order for Bumex (?) mgs daily for edema. The ordered dose for Bumex was not clear as to 5 mgs or 0.5 mgs.</p> <p>The nurse's notes dated 8/6/13 indicated that the Bumex needed to be clarified with the doctor in the morning. As of 8/21/13, there was no documentation that the Bumex had been clarified with the doctor.</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> 1. Unit manager notified medical doctor, responsible party on 8/21/13, of missed administration of diuretic. Unit manager clarified order and added to Medication administration record on 8/21/13. 2. Director of Clinical Services and or unit manager completed an audit on 9/17/13 for residents currently Residing in the facility with diuretic orders, to ensure orders were transcribed correctly to medication administration record. No other residents were found to be affected. 3. Director of clinical services and or unit manager provided and completed education to licensed nurses on 9/17/13, regarding, obtaining clarification orders for diuretics and transcribing to the medication administration record this education included prn /weekend licensed staff/ those unable to attend. The Director of clinical services and or unit manager will utilize a QI tool to review resident orders 5x week X 4 weeks, 3x week X 4 weeks, then weekly X 4 weeks, to ensure that diuretic orders are written and transcribed correctly. 4. The Director of clinical services and or unit manager will report the results of the QI Tools to the quality assurance committee monthly X 3 months, as well as revisions required to sustain substantial compliance. 		

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F 309	Continued From page 18 The MAR for August, 2013 was reviewed. Bumex was not transcribed to the MAR and therefore was not administered to Resident #8. On 8/21/13 at 1:00 PM, the feet of Resident #8 were observed. Both feet were swollen. At 1:05 PM, Nurse # 3 was interviewed. She went to assess the feet of Resident #8 and stated that they were both swollen with 3 + (plus) edema. She further stated that she was not aware about the swelling and nobody had informed her. The nurse's notes dated 8/21/13 at 2:00 PM revealed the Resident #8 was noted with 3 + edema on both lower extremities. The left lower extremity was noted to be weeping. On 8/21/13 at 3:55 PM, administrative staff #6 was interviewed. She stated that she was scheduled to work Monday thru Friday and nobody had informed her to clarify the Bumex with the doctor. She added that the Bumex was not administered since 8/6/13 because nobody had called the doctor to verify the dose. On 8/21/13 at 4:30 PM, administrative staff #7 was interviewed. She stated that she had called the doctor and informed him that Bumex had not been administered to Resident #8 because the dose needed to be clarified. The doctor had ordered to administer 0.5 mgs of Bumex. The nurse who signed off the order for Bumex on 8/6/13 was not available for interview.	F 309			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		September 19, 2013	

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F 334	<p>Continued From page 19</p> <p>that ensure that –</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that –</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal</p>	F 334	<p>F334</p> <p>1. The Director of Clinical Services notified medical director, and responsible party of resident #14, #46 on 9/12/13 of missed influenza vaccination for the 2012-2013 influenza season.</p> <p>2. The Director of clinical services completed an audit on 9/13/13 for the Residents currently residing in the facility, to ensure That consent for influenza vaccinations were offered.</p> <p>3. The Director of clinical services and or unit manager will provide education to all licensed nurses on 9/17/13, in reference to obtaining influenza consents, and offering influenza vaccinations. 2013-2014 consent forms and vaccine information documents were mailed the week of 9/8/13. A QI tool was developed for residents which will receive a consent form. If consent forms are not returned to the facility by Friday, October 18, 2013, the Director of clinical services and or unit manager will attempt to obtain consent by the phone. If the Director of clinical services and or unit manager is unable to reach responsible party by phone, a certified letter will be</p>	
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F 334	<p>Continued From page 20</p> <p>representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to offer the annual influenza vaccine to 2 (Residents #14 & #46) of 5 sampled residents. Findings included:</p> <p>The facility's policy on Influenza Vaccine dated 1/1/2012 (revision date) was reviewed. The policy read in part "all residents will be offered an influenza vaccine according to the local health department guidelines. The guidelines included to obtain physician's order, offer the resident the influenza vaccine if medically indicated, and obtain an informed consent from the resident or</p>	F 334	<p>sent to responsible party .Medical Doctor will be notified as well. The Director of clinical services and or unit manager will utilize a QI tool to monitor during months October – May, to ensure that residents currently residing in the facility have been offered an influenza vaccination.</p> <p>4. The Director of clinical services and or unit manager will report the results of the QI tool to the Quality assurance performance committee monthly x 3, as well as revisions required to sustain substantial compliance.</p>		

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F 334	<p>Continued From page 21</p> <p>responsible party if indicated. Explain the potential risks/side effects/benefits of the vaccine. Have resident/responsible party sign the consent, indicating the desire to receive the vaccine or the wish to decline and obtain specific influenza vaccine information from the web site and attach to consent. Provide copy of the information to the resident/responsible party." The policy also indicated that the consent should be filed in the medical record.</p> <p>1. Resident # 14 was admitted to the facility on 10/13/09 with multiple diagnoses including Dementia, Hypertension and Diabetes Mellitus. The significant change in status assessment dated 5/17/13 indicated that Resident #14 had memory and decision making problems.</p> <p>Review of the immunization record revealed that Resident #14 had not received the influenza vaccine for 2012/2013 influenza season.</p> <p>On 8/22/13 at 11:15 AM, administrative staff #7 was interviewed. She stated that she was responsible for making sure residents had received the influenza and pneumococcal immunization. She stated that the consent/education materials were mailed to the responsible party but the consent was not returned back. She did not provide information as to when it was mailed. There was no documentation in the medical records that the consent and education materials were mailed to the responsible party. She added that she should have followed it up by calling the responsible party but she did not.</p> <p>2. Resident #46 was admitted to the facility on</p>	F 334			

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F 334	Continued From page 22 5/7/12 with multiple diagnoses including dementia, Hypertension and Diabetes Mellitus. The significant change in status assessment dated 7/3/13 indicated that Resident #46 had severe cognitive impairment. Review of the immunization record revealed that Resident #46 had not received the influenza vaccine for 2012/2013 influenza season. On 8/22/13 at 11:15 AM, administrative staff #7 was interviewed. She stated that she was responsible for making sure residents had received the influenza and pneumococcal immunization. She stated that the consent/education materials were mailed to the responsible party but the consent was not returned back. She did not provide information as to when it was mailed. There was no documentation in the medical records that the consent and education materials were mailed to the responsible party. She added that she should have followed it up by calling the responsible party but she did not. The family member of Resident #46 was observed visiting every day.	F 334			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356	F 356 1. Daily staffing with accurate information is posted daily by unit manager and or licensed nursing personnel. 2. No other residents were identified to be affected. 3. The unit manager was educated on 9/17/13, to the requirements of posting accurate complete staffing information to include only skilled census on a daily basis by the Director of Clinical Services. The weekend	September 19, 2013	

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F 356	<p>Continued From page 23</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the resident census was accurate on the "Daily Nursing Staffing Form" on 4 consecutive days of the survey.</p> <p>The findings included:</p> <p>Review of the "Daily Nursing Staffing Forms" dated 8/19 13 - 8/22/13 revealed a consistent census of 62. The number of certified beds in the facility was 60.</p> <p>During an interview on 8/22/13 at 12:24 PM, Administrative Staff #7 indicated that she was</p>	F 356	<p>supervisor and licensed nurses were educated regarding posting of accurate daily staffing by the Director of Clinical services/ unit manager on 9/17/13. A quality improvement tool will be completed by the Director of Clinical Services and or unit manager 5x a week x 2 weeks. 3x a week x 2 weeks, then weekly x 8 weeks to ensure daily staffing posting is accurate and complete.</p> <p>4. The Director of Clinical Services and or unit manager will report the results of the QI tools to the Quality assurance committee monthly x 3 months to Identify trends and need for further education and/ or monitoring, as well as revisions required to sustain substantial compliance.</p>		

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F 356	Continued From page 24 unaware the daily staffing form should only include data pertaining to the skilled beds in the facility.	F 356			
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that 1 (Resident #8) of 2 sampled residents received the thickened liquids as ordered. The findings included: Resident #8 was admitted to the facility on 3/13/13 and was re-admitted on 7/8/13 with multiple diagnoses including metabolic encephalopathy. The quarterly Minimum Data Set (MDS) assessment dated 7/16/13 indicated that Resident #8 had impaired cognition and with swallowing problem. The care plan dated 7/18/13 was reviewed. There was no care plan developed to address the swallowing problem. On 7/11/13, there was a doctor's order to change the texture of diet to puree. On 8/9/13, there was a clarification order for "speech therapy 5 times per week for 4 weeks for	F 365	F365 September 19, 2013 1. Resident #8 was assessed on 8/22/13 by Director of clinical services, and there are no adverse outcomes. 2. The minimum data set nurse and or dietary manager conducted an audit of physician orders, for residents residing in the facility to ensure that orders are written for the appropriate Consistency. Audit was completed on 9/18/13. On 9/18/13, the minimum data set nurse and or dietary manager conducted a tray ticket audit for residents currently residing in the facility to determine that tray tickets consistent with physician order. Two problems were identified, with no adverse actions 3. The Dietary manager provided education to		

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F 365	<p>Continued From page 25</p> <p>dysphagia and symbolic dysfunction, may include dysphagia therapy and cognitive-linguistic therapy."</p> <p>On 8/14/13, there was an order to change diet to nectar thick liquids.</p> <p>On 8/21/13 at 12:40 PM, Resident #8 was observed in bed eating lunch. Her tray contained puree food, nectar thick water and a glass of thin juice. At 12:45 PM, Nurse #3 was interviewed. She acknowledged that the juice was not thickened and she took it back to the kitchen. She stated that Resident #8 was on nectar thick liquids and dietary department was responsible for thickening the liquids.</p> <p>On 8/22/13 at 8:25 AM, Resident #8 was observed in the dining room eating breakfast. She was observed holding a carton of whole milk and was drinking it. She was observed coughing and clearing her throat while drinking the milk. There were staff members in the dining room feeding other residents. At 8:33 AM, administrative staff #5 was interviewed. The administrative staff observed Resident #8 drinking the whole milk and stated that it was served by mistake as the resident was on nectar thick liquids.</p> <p>On 8/22/13 at 5:05 PM, administrative staff #1 shared additional information. She stated that the juice that was served during lunch had a thickener on it but it was not mixed before serving. She also stated that a staff member had observed Resident # 19 (family member) went to the kitchen and asked for a carton of milk and gave it to Resident #8.</p>	F 365	<p>100% of dietary staff on 8/23/13</p> <p>In reference to shaking thickened liquid cartons, prior to pouring them and Serving residents.</p> <p>The Director of clinical services and or unit manager provided education to all Nursing staff on 9/18/13, in reference to provision of thickened liquids as ordered to residents. The Dietary manager and or dietary aide will utilize A QI monitoring tool will be used to check tray card against resident trays, for residents on thickened liquids, to ensure there is proper consistency on tray, 7xweek X 4 weeks, then 5xweek X 2 months.</p> <p>4. The QI tools will be forwarded to the quality assurance committee by the dietary manager Monthly X 3, as well as revisions required to sustain substantial compliance.</p>		

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F 368 F 368 SS=E	Continued From page 26 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on facility meal time schedules, resident and staff interviews and a review of Resident Council minutes, the facility failed to provide nourishing snacks at bedtime. The findings included: The facility meal time schedule stated breakfast was served from 8:00AM. to 8:35AM. and dinner (evening meal) was served form 4:45 PM. to 5:20 PM. On 2/25/13, a review of Resident Council Minutes revealed residents indicated they would like to see more snacks in the snack room and on the snack cart in the evenings.	F 368 F 368	F368 1. Adjustments were made to the meal delivery times to ensure the meals are delivered within the required 14 hour time frame. Meal times are now: breakfast 1 st dining 7:30 am 2 nd dining 8:05 am; lunch 1 st dining 12:00pm 2 nd dining 12:35pm; dinner 1 st dining 5:10 pm 2 nd dining 5:45pm 2. Residents currently residing in the facility have the potential to be affected. 3. The Dietary manager provided education to dietary staff on 8/27/13. The Director of Clinical Services and or unit manager conducted education to nursing staff, regarding snacks on 9/12/13 . Education consisted of nursing staff utilizing a check off sheet to indicate that residents are offered snacks during scheduled snack times. The dietary manager utilizes an inventory sheet to ensure that Par level snacks are replenished in the nourishment room, to ensure there are enough snacks available. To ensure that snacks are available in the absence of dietary staff, nursing staff has been educated on 9/17/13 by the director of clinical services and or unit manager on where to obtain dietary keys to get additional nourishing snacks. The dietary manager has educated dietary staff regarding delivery of	September 19, 2013	

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F 368	<p>Continued From page 27 .</p> <p>On 3/18/13, a review of Resident Council Minutes revealed residents stated there were still concerns with the snacks for the snack cart. The dietary person was present and stated food items had been ordered and the following items should be on the snack cart soon—gold fish, oatmeal creme pies, moon pies, cookies, cheese crackers, fudge rounds, etc.</p> <p>On 4/19/13, a review of Resident Council Minutes stated residents on E hall stated the only time snacks were offered was when a particular nursing assistant was working.</p> <p>On 5/24/13, a review of Resident Council Minutes stated residents on E hall stated they were provided snacks for two nights, then snack were no longer offered.</p> <p>On 6/17/13, a review of Resident Council Minutes revealed residents stated no daytime snacks were being offered. F hall stated second shift was the only shift to give out snacks. Residents were informed about the nourishment room on E hall where snacks were available. One resident on E hall stated there were no snacks available on 6/16/13.</p> <p>On 7/22/13, a review of Resident Council Minutes stated D hall residents stated no snacks were being offered. A hall stated there were very few choices/ amount of snacks in the evening. The social worker reminded the residents about the nourishment room on E hall and residents responded there were few snacks in there and the room was not wheelchair accessible.</p> <p>On 8/15/13, a review of Resident Council Minutes</p>	F 368	<p>snacks on 9/9/13 and education of meal Delivery times on 8/27/13. The dietary manager will utilize a QI monitoring tool to monitor the inventory of snacks in the nourishment room 5xweek .The dietary manager and or dietary aide and or dietary cook will utilize A QI tool to monitor that snacks are delivered 7xweekX 4 weeks, then 5xweek X 2 months. The dietary manager/ aide/ cook will utilize a QI tool to monitor that meal delivery follows adjusted time frames 7xweekX 4 weeks, then 5xweek X 2 months. The nursing staff will utilize a QI monitoring tool to indicate each resident was offered a snack during snack times 7xweek X 4 weeks, then 5xweek X 2 months.</p> <p>4. The Dietary manager will forward results of the QI monitoring tools to the quality assurance committee</p> <p>Monthly X 3 months, as well as revisions Required to sustain substantial compliance.</p>		

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F 368	<p>Continued From page 28</p> <p>indicated C hall residents stated first shift forgot C hall when snacks were given out. All residents agreed that residents sometimes did not get snacks left in their room. All residents agreed that second shift gave out snacks.</p> <p>On 8/19/13 at 6:38 PM., a tour of the kitchen revealed the kitchen had been cleaned and dietary staff stated they were done for the night. No food was being served at that time.</p> <p>On 8/20/13 at 8:11 AM., residents on A hall began receiving breakfast trays. Resident # 92 did not receive her breakfast tray until 8:50AM.</p> <p>On 8/21/13 at 11:30 AM., the dietary manager, district dietary manager and regional representative for dietary stated they were not aware of the fifteen hour span between the dinner meal and the breakfast meal the next day. The snack items available were mostly "junk food" items and consisted of peanut butter crackers, animal crackers, chips and cookies. Peanut butter and jelly sandwiches were for specific residents only. They did not indicate what would be considered a nourishing snack.</p> <p>On 8/21/13 at 9:33AM., Resident #64 stated nursing staff sometimes said they did not have any snacks to give out (day shift and/or evening shift).</p> <p>On 8/21/13 at 1:03 PM., NA #3 stated she had just recently come to day shift from evening shift. She said evening snacks were passed out around 7:00 pm. The snacks available were whatever dietary provided and consisted most of "junk type" food-cookies, crackers. NA #3 stated there used to be more sandwiches provided but that</p>	F 368			

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F 368	<p>Continued From page 29</p> <p>had not been done for the past two months. She said nursing staff could not make a peanut butter/ jelly sandwich if someone asked because the kitchen was locked and those items were not available for nursing staff to make the sandwiches.</p> <p>On 8/21/13 at 3:25PM., Resident #9 stated evening snacks consisted of peanut butter crackers, potato chips and cookies--mostly junk food. Resident #9 said they had sandwiches on the snack cart but they were for certain people.</p> <p>On 8/21/13 at 3:55 PM., the district dietary person and the regional person stated they were informed by one of the dietary staff that the nursing staff could go in to the kitchen at any time and showed surveyor a key that was available when dietary staff not in facility.</p> <p>On 8/21/13 4:03 PM., Nurse #2 stated the dietary staff brought out snacks every evening for the nursing staff to give to the residents. Most snacks consisted of crackers, chips and cookies. She said she had not seen any sandwiches provided. Nurse #2 stated she did not know if there was a key available so staff could obtain snacks from the kitchen.</p> <p>On 8/21/13 at 4:15 PM., NA #4 stated evening snacks available consisted of cookies, chips, graham crackers and saltines. She stated snacks were passed out between 6:30 PM. and 7:00 PM. and sometimes, there wasn't much left to choose from by the time the snacks were distributed on D and E halls. NA #4 said there were many times when there were not enough snacks to go around although it had been getting better since they had new dietary people.</p>	F 368			

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F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and date/discard out-dated food/liquids in the kitchen refrigerator and the nourishment refrigerator. Findings included:</p> <p>1. On 8/21/13 at 11:03 AM., an observation of the refrigerator in the dietary department revealed one 23 ounce container of thickened apple juice opened 5/2/13. There was also one 32 ounce container of thickened cranberry juice cocktail opened and undated and one 32 ounce container of thickened dairy drink opened and undated.</p> <p>On 8/21/13 at 11:03 AM., the dietary manager stated the opened containers should have been dated when opened and the container of thickened apple juice should have been discarded at least within seven days after being opened.</p> <p>2. On 8/21/13 at 4:30 PM., an observation of the nourishment refrigerator revealed one carton of Resource Breeze supplement with the manufacturer's expiration date of 8/15/13 and</p>	F 371	<p>F371</p> <p>1. Out dated items located in nourishment room refrigerator and kitchen Refrigerator were discarded during survey by the dietary manager on 8/21/13.</p> <p>2. Nourishment room and kitchen refrigerator were searched for other outdated items by dietary manager starting on 8/21 to present No other items were found.</p> <p>3. Dietary manager provided education to 100% dietary staff regarding dating items on 8/21/13 and discarding out dated Items in the refrigerator on 9/17/13 Dietary manager and or morning cook will utilize QI monitoring tools to monitor items in nourishment Room refrigerator and kitchen refrigerator, to include weekends 7xweek X 4 weeks, then 5xweek X 2months. To ensure that staff are dating refrigerated items, and discarding outdated items. The nursing staff has also received education on discarding expired foods on 9/17/13 by the director of clinical services.</p> <p>4. Dietary manager will report results of the QI Monitoring tools to the Quality assurance committee monthly X 3, As well as revision required to sustain substantial compliance.</p>	September 19, 2013.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2013
NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
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F 371	Continued From page 31 three eight ounce bottles of Ensure supplement with the manufacturer's expiration date of 8/1/13. On 8/21/13 at 5:30 PM., the dietary manager stated the dietary staff checked the nourishment refrigerator every morning and would discard any expired/ outdated items. He said he had instructed his dietary staff not to check the supplements in the nourishment refrigerator because they were placed there by the nursing staff. On 8/21/13 at 5:30 PM., Administrative staff #1 stated she thought all of the items in the nourishment refrigerator was checked by dietary and items discarded if expired/ outdated.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F441 1. Isolation signs placed on doors of resident #72 and #92 on 8/21/13 by charge nurse. 2. Residents currently residing in facility requiring isolation Were reviewed by Director of Clinical Services. Visual observation was done on 8/23/13. No other residents were identified. 3. Director of Clinical Services and or unit manager will provided education to nursing staff and central supply on how to properly set up a room for isolation, including posting correct signs. Education included weekends, Prn, and other licensed staff unable to attend the in-service. Education completed on 9/17/13.	September 19, 2013	

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F 441	<p>Continued From page 32</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to post isolation signs on the doors of 2 (Residents # 72 & #92) of 3 sampled residents on isolation. The findings included:</p> <p>The facility's policy on isolation precaution dated 1/1/09 (revised date) was reviewed. The policy indicated that the facility was using standard precaution for all residents and airborne, droplet and contact isolation for residents who are known or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens that can be transmitted by airborne, droplet or contact. The policy did not specify what precaution to use for a C-diff (Clostridium difficile) infection.</p>	F 441	<p>The Director of Clinical Services and or unit manager will utilize a QI tool to review/monitor current residents on isolation, to include weekends 5x week X 4 weeks, 3x week X 4, then once a week X 4 weeks. This review will ensure personal protective equipment and that correct isolation signs are posted on doors.</p> <p>4. The Director of clinical services and or unit manager will report the results of the QI tool To The Quality assurance Committee monthly X 3, as well as revisions Required to sustain substantial compliance.</p>		

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F 441	<p>Continued From page 33</p> <p>1. Resident #72 was originally admitted to the facility on 10/3/12 and was re-admitted on 7/5/13 with multiple diagnoses including Alzheimer's disease, Dementia and C-diff.</p> <p>The laboratory reports were reviewed. On 8/6/13, the result for stool for C-diff toxin was positive.</p> <p>Review of the telephone orders revealed that on 8/6/13, there was an order for Vancomycin (antibiotic) 250 mgs (milligrams) four times a day for C-diff and to start isolation precaution for C-diff.</p> <p>On 8/19/13 at 6:15 PM, 8/20/13 at 4:30 PM and 8/21/13 at 10:25 AM, observation of Resident #72's room was conducted. There was an isolation cart observed outside the room but there was no sign to indicate what type of isolation the resident was on.</p> <p>On 8/21/13 at 10:12 AM, Housekeeper #1 was interviewed. She stated that the resident was on isolation for Methicillin Resistant Staphylococcus Aureus.</p> <p>On 8/21/13 at 10:20 AM, Nurse #1 was interviewed. She stated that Resident #72 was on contact precaution for C-diff. She added that the sign should have been hung on the door but acknowledged that she did not see the sign on the door. She indicated that the sign might have fallen off.</p> <p>2. Resident # 92 was admitted to the facility on 5/28/13. Cumulative diagnoses included C-diff. Clostridium Difficile is bacteria with the most common symptom being diarrhea. .</p>	F 441			

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F 441	<p>Continued From page 34</p> <p>A review of physician's orders revealed an order dated 7/28/13 for a stool culture for c-diff.</p> <p>Laboratory results dated 8/1/13 indicated the test was positive for c-diff.</p> <p>A care plan dated 8/8/13 indicated Resident #92 required isolation due to c.diff.</p> <p>On 8/20/13 at 8:00 AM., an observation revealed Resident #92 had PPE (personal protective equipment) on her door. There was no isolation sign on her room.</p> <p>On 8/20/13 at 12:30 PM., an observation revealed Resident #92 had PPE equipment on her door but did not have an isolation sign on her door.</p> <p>On 8/21/13 at 8:00 AM., Resident #92 was observed to have PPE equipment on her door with no isolation sign on the door.</p> <p>On 8/21/13 at 10:26 AM., Nurse #1 stated Resident #92 had c-diff. She stated it was facility policy to put up an isolation sign when a resident was on isolation and Resident #92 should have had a sign on her door. Nurse #1 stated the sign must have fallen off.</p> <p>On 8/21/13 at 10:26 AM., nursing assistant (NA) #1 stated Resident #92 had c-diff and, normally, there would be a sign on the door that indicated isolation precautions should be observed.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 820 HEATHWOOD DRIVE ALBEMARLE, NC 28001
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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III (211) protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system.	K 000		
K 025 SS=0	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 9/10/2013 the following Life Safety item was observed as noncompliant, specific findings include: There were unsealed penetrations in the rated ceiling at the following locations: 1. The dining room mechanical room ceiling. 2. The dietary mechanical room ceiling.	K 025	October 14, 2013 K 025 1. Ceilings in the dining room mechanical room, and the dietary mechanical room were sealed with fire barrier sealant on September 10, 2013. 2. Residents residing in the facility have the potential to be affected. 3. Maintenance personnel will utilize a quality improvement tool to check for unsealed penetrations throughout the facility. The quality improvement tool will be utilized weekly x 4 weeks, then once a month x 2 months. 4. Results of the quality improvement tools will be monitored by the administrator/maintenance personnel, then forwarded to the quality assurance committee monthly x 3 months, as well as revisions required to sustain substantial compliance. 5. Corrective action completion date of 10-14-13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *9/25/13*

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

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NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	
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K 025	Continued From page 1	K 025		
K 144 SS=F	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by. Based on the observations and staff interviews on 9/10/2013 the following Life Safety item was observed as noncompliant, specific findings include: The generator transfer switch was not operational during the survey.	K 144		October 14, 2013
K 147 SS=F	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by. Based on the observations and staff interviews on 9/10/2013 the following Life Safety item was observed as noncompliant, specific findings include: The exit discharge lighting from the "E" hall exit was not verified to be on the emergency circuit to the public way.	K 147		October 14, 2013
		K 147		
			K 144	
			1. Generator transfer switch has been ordered with Kraft Power. 2. Residents residing in the facility have the potential to be affected. 3. Maintenance personnel will utilize a quality improvement tool to perform generator checks weekly x 12 weeks. 4. Results of the quality improvement tools will be monitored by the administrator/ maintenance personnel, then forwarded to the quality assurance committee monthly x 3 months, as well as revisions required to sustain substantial compliance. 5. Corrective action completion date of 10-14-13.	
			K 147	
			1. "D" Hall exit lighting gives adequate lighting to the "E" hall public way. D Hall exit lighting was verified to be on the emergency circuit on 9-24-13. Correct bulb was placed in light fixture as well on 9-24-13. 2. Residents residing in the facility have the potential to be affected.	

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NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001
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K 147	Continued From page 2 CFR#: 42 CFR 483.70 (a)	K 147	<p>3. Maintenance personnel will ensure E hall public way has adequate lighting through the use of a quality improvement tool. The quality improvement tool will be utilized 3x/wk x 12 weeks.</p> <p>4. Results of the quality improvement tools will be forwarded to the quality assurance committee monthly x 3, as well as revisions required to sustain substantial compliance.</p> <p>5. Corrective action completion date of 10-14-13</p>	
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