

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/07/2013
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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF STATESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 VANHAVEN DRIVE STATESVILLE, NC 28625
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F 000	INITIAL COMMENTS 483.25 (F323) at J Immediate Jeopardy began on 09/06/13 when the facility failed to secure the wheelchairs of Resident #70 and Resident #5 in the facility van prior to transport. The Administrator was informed of Immediate Jeopardy on 09/06/13 and Immediate Jeopardy was removed on 09/07/13 at 5:20 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice; 2. How will you identify other issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken; 3. What measures will be put into place or what systemic changes you will make to insure that the alleged deficient practice does not recur; 4. How the corrective action(s) will be monitored to ensure that the alleged deficient practice does not recur; 5. Include dates when corrective action will be completed. The dates of corrective action must be acceptable to the State.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to have a documented medical symptom for 1 of 3 residents (Resident #68) with a restraint. Findings Included: 1. Resident #68 was admitted to the facility on 01/03/11 with diagnoses which included Alzheimer's disease, cerebrovascular accident, and hypertension. The most recent Annual Minimum Data Set (MDS) dated 09/07/13	F 221	F221 It is the policy of this facility to strive for a restraint free environment for all residents. One of the ways this has been achieved for resident #68 is by periodically reviewing side rails to ensure resident #68 uses them to enhance turning and positioning mobility while in the bed. Resident # 68 continues to reside in the facility and was rescreened for side rail use 9/24/13 by the Regional nurse consultant. Resident #68 expressed desire to have side rails up and acknowledges using the side rails to assist with	9/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K. Daniel Goodwin

Administrator Black 10/4/13

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 30 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.

original signature 9/30/13mh



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F 221	<p>Continued From page 1</p> <p>indicated that the resident was severely cognitively impaired. In addition, the resident required limited assistance from staff for bed mobility and transfer and required extensive assistance for all activities of daily living (ADL) and uses a wheelchair. The resident was assessed as having no impairment in range of motion of upper and lower extremity on both sides of his body. The section for Physical Restraints documented that the resident had no physical restraints. The section for falls documented that the resident had no history of falls. The section for functional ability documented the resident was not steady when transferring between bed and wheelchair, but was able to stabilize without human assistance.</p> <p>Review of Resident #68's care plan dated 07/10/13 revealed Resident #68 needs limited assistance to turn in bed due to his physical and medical conditions. The care plan also said Resident uses full side rails to assist with bed mobility as needed.</p> <p>Review of Resident #68's side rail screen, dated 06/19/13, revealed Resident #68 did not have cognitive deficit, had no history of falls, has not expressed desire to have side rails on bed but uses them for positioning in bed and establishing bed parameters.</p> <p>Interview with Nurse #1 on 09/03/13 at 12:23 PM revealed resident used full side rails to prevent him from getting up from the bed and falling. Nurse #1 said Resident #68 would be physically able to get out of bed on his own without the full side rails used on his bed.</p> <p>Observation of Resident #68 on 09/04/13 at 3:45</p>	F 221	<p>F221 (cont'd) positioning. Resident # 68 is able to follow requests to assist as was evident via returned demonstration 9/24/13. Resident # 68 experienced no negative outcomes. For other residents with the potential to be affected by the same alleged deficient practice the following has been done. Direct care staff was in serviced and re-educated by the Administrator for side rails defined as a restraint and their use.</p> <p>A 100% audit of all residents was completed by the ADON to re-screen residents using side rails. A quality assurance form was created to screen residents for side rail use for positioning enablers and resident preference.</p> <p>Each resident is assessed on admission, quarterly, and with significant change in condition for side rail use, utilizing the facility side rail assessment form available in the electronic record. The Assistant Director of Nursing will audit 2 residents daily Monday - Friday for 8 weeks for Side rail use to ensure the side rails are not being used</p>	
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F 221	<p>Continued From page 2</p> <p>PM in bed with full side rails raised along the distance of his entire body. Resident's wheelchair was observed at end of bed, against part of bed free of side rails.</p> <p>Interview with nurse aide (NA) #5 on 09/07/13 at 11:09 AM revealed she has observed Resident #68 moving himself around in his bed on many occasions. NA #5 reported she has worked with Resident #68 since his admission in 2011. NA #5 said Resident #68 would be physically able to get himself up from bed but his full side rails prevent him from getting out of bed.</p> <p>Interview with MDS coordinator on 09/07/13 at 1:36 PM revealed that Resident #68 uses full side rails, which she does not consider to be a restraint because they assist him in being able to move around while in bed. MDS coordinator stated Resident #68 could fall from the bed if full side rails were not used. MDS coordinator stated they had not attempted any other equipment to assist Resident #68 to be mobile in bed.</p> <p>Interview with director of nursing on 09/07/13 at 4:45 PM revealed a committee including the MDS coordinator and the assistant director of nursing (ADON) reviewed each resident for restraints and side rails and determines the appropriateness of their use at least quarterly. The DON reported most of the beds in the facility have full side rails which limit the residents to either having full side rails or no side rails.</p> <p>Interview with ADON on 09/07/13 at 5:00 PM revealed she has checked Resident #68's side rails quarterly to ensure they are assisting him with being able to move around in bed. ADON reported she does not assess whether or not full</p>	F 221	<p>as restraints. Then the Assistant Director of Nursing will audit 1 resident daily Monday - Friday for 4 weeks for side rail use to ensure the side rails are not being used as restraints.</p> <p>The Director of Nursing, Assistant Director of Nursing and Therapy Director review each resident's side rails quarterly during at risk meeting. The Assistant Director of Nursing is responsible for compliance and presents concerns to Quality Assurance committee quarterly.</p>	
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F 221	Continued From page 3 side rails prevent Resident #68 from getting out of bed. ADON said she did not know if Resident #68 could physically get out of bed without the presence of the full side rails. The ADON said the quarterly screen she conducted on Resident #68 did not include talking with staff or determining if the device restricted a resident's voluntary movements. In the case of Resident #68 she was unaware that he could get out of bed and felt that the side rails enabled him to move freely in bed without falling out. ADON stated the facility beds were old and they continued to use beds with full side rails for residents who benefited from using them to help move around in bed and not fall from the bed. ADON said typically the beds in the facility with full side rails were used instead of using half side rails because that is the kind of bed the facility owned. The ADON said her definition of restraint was something that restricted the resident ' s natural movement. She stated if staff said Resident #68 could get out of the bed but the rails prevented him from getting out of bed, the rails were a restraint.	F 221			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225	F- 225 It is the policy of this facility to investigate and report allegations of abuse/neglect, mistreatment, and injuries of unknown origin. Resident # 35 and # 8 continue to reside in the facility and have experienced no negative outcomes. This was achieved for residents # 35 and #8 by the following: The Administrator and Director of nurses were inserviced by the regional nurse consultant for definitions and state, federal	9/30/13	

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F 225	<p>Continued From page 4 or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to report an injury of unknown origin and a resident's complaint of staff being rough within 24 hours to the State's Health Care Personnel Registry (HCPR) for 1 of 1 resident with an injury of unknown origin (Resident #35) and 1 of 2 resident complaints of staff being rough (Resident #8).</p> <p>The findings included:</p>	F 225	<p>F225(cont'd) law for reporting all allegations of abuse/neglect, mistreatment, and injury of unknown origin. Resident #35 and #8 were re-interviewed by the Regional Nurse consultant on 9/24/13 and each express feeling safe and comfortable in the facility. Each resident was informed of their right to express concerns when they have an allegation of abuse neglect. For other residents with the potential to be affected by this alleged deficient practice the following has been achieved:</p> <p>All staff was in-serviced for reporting allegations of abuse/neglect, mistreatment, and injury of unknown origin as is facility policy and according to State and Federal Regulation 9/27/13. The Director of nurses and administrator were in serviced for reporting of abuse neglect, mistreatment, and injury of unknown origin as per facility policy and state and federal regulation by the Regional Nurse Consultant. The facility follows the procedure to report all allegations of abuse/neglect, unknown origin and mistreatment to the appropriate state agency as is policy and required by state and federal regulation by the Administrator, Director of</p>		

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F 225	<p>Continued From page 5</p> <p>1. Resident #35 was admitted to the facility on 06/07/12 with diagnoses that included difficulty walking, hypertension, history of cerebrovascular accident, history of fractured lower leg and others. The Minimum Data Set (MDS) dated 02/21/13 specified the resident had moderately impaired cognition and required extensive assistance of two persons with transfers and bed mobility. The MDS also specified the resident did not refuse care and had no behaviors such as being physically abusive towards staff.</p> <p>Review of the medical record revealed a Social Services' entry dated 5/17/13 that specified the "Resident was alert and oriented to self and family only. Resident does have confusion." On 05/19/13 a nurse's entry documented that the resident complained of knee pain. An additional nurse's entry dated 05/20/13 specified, the resident was placed on an every 2 hour turning and repositioning program to decrease pressure related to history of pressure ulcers.</p> <p>Further review of the medical record revealed on 05/20/13 the nurse received a physician's order to x-ray the resident's left knee and hip due to continued complaints of pain. The x-ray results revealed the resident had a fractured femur and the physician ordered to send the resident to the hospital.</p> <p>The Care Area Assessment (CAA) for cognition dated 06/07/13 specified Resident #35 at times had a delayed thought process and delayed responses. The resident at times missed some of what was said and that staff had to repeat what was said over and offer cueing and reminders. When the resident was given choices she was able to make them. She had recent</p>	F 225	<p>F225(cont'd) Nurses, Social Worker or Assistant Director of Nurses. Each allegation is reported to the Health Care Personnel Agency and/or other state agency within 24 hours, investigated, witness statements obtained and followed up by the Director of Nursing and/or Assistant Director of Nursing and/or Social Worker in 5 working days as per regulation. Corrections for this alleged deficient practice will be accomplished by September 30, 2013. The Quality Assurance Committee will review Abuse and Grievance logs quarterly to assure accurate and compliant reporting.</p>		

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F 225	<p>Continued From page 6</p> <p>hospitalization (05/20/13) related to a fractured distal femur with unknown etiology and was downgraded from the "sit to stand lift" to a total mechanical lift.</p> <p>On 09/05/13 at 10:00 AM Resident #35 was observed in bed transferred by nurse aide #1 and nurse aide #2. The nurse aides used a mechanical lift to transfer the resident from the bed to her geri chair (a recliner type wheelchair). The Resident was observed to hold on to the side rails of her bed and the nurse aides coaxed her to release the rails so they could perform the transfer. Nurse aide #1 stated that ever since the resident broke her leg she's been very fearful of being in the mechanical lift and likes to hold on to the side rails. Both nurse aides reported that they worked with Resident #35 on a regular basis prior to fractured leg and they were unaware of how she sustained the fracture. The nurse aides reported that Resident #35 did not refuse care but could at times become agitated during care.</p> <p>On 09/05/13 at 10:50 AM Nurse #2 was interviewed and reported that she cared for Resident #35 routinely and she was unaware of how the fracture occurred. She stated that it was most likely from brittle bones.</p> <p>On 09/06/13 at 4:10 PM the Director of Nursing (DON) was interviewed and reported that there was no incident report related to Resident #35's fractured femur because "nothing happened." She added that Resident #35 started complaining of pain which was unusual for her and the nurse notified the physician who ordered an x-ray. She explained that the x-ray results did not specify the fracture was trauma related and she spoke with the physician who told her that given her</p>	F 225		
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F 225	<p>Continued From page 7</p> <p>co-morbidities it was very likely for her bones to spontaneously break. The DON confirmed she did not report the injury of unknown origin to the HCPR within 24 hours because she did not consider the injury to be suspicious. She thought she had spoken with staff when she returned to work about the incident but had no documentation of staff statements. The DON explained that given her diagnoses she felt there was no "unknown" variable that caused the resident to sustain a fractured femur. She stated that Resident #35 returned to the facility after being in the hospital related to the fracture. After the Resident returned to the facility the DON asked the resident if she had fallen or had been mistreated by staff. The DON explained that she felt the resident was "with it enough" to answer the questions and reported that she had not fallen and had not been mistreated by staff.</p> <p>On 09/06/13 at 4:50 PM the Regional Consultant was interviewed and reported that Administrators and Directors of Nursing were trained to immediately report any allegations of abuse and injuries of unknown origin. The Regional Consultant defined injury of unknown origin as suspicious in nature and the resident was unable to report what caused the injury. She stated that she expected the facility to report within 24 hours to the HCPR to err on the side of caution and then proceed with an investigation to determine the cause of the injury. The Regional Consultant also felt that Resident #35's fractured femur was a result of a pathological fracture but agreed there was no documented investigation to validate the claim.</p> <p>On 09/07/13 at 3:35 PM the Administrator was interviewed and reported that the facility</p>	F 225		
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F 225	<p>Continued From page 8</p> <p>investigated anything that was not able to be explained. He agreed that initially a 24 hour report should have been filed with the HCPR and then an investigation should have been completed.</p> <p>2. Resident #8 was admitted to the facility on 06/21/13 with diagnoses that included cerebrovascular accident, abnormality of gait, difficulty in walking and others. The Minimum Data Set (MDS) dated 07/03/13 specified the resident was cognitively intact and required limited assistance with most ADL and extensive assist with bed mobility and transitioning from the bed to the wheelchair. The MDS also specified the resident did not refuse care and had no behaviors such as being physically abusive towards staff.</p> <p>Review of facility grievance records revealed on 06/27/13, Resident #8 had reported to Nurse #5 that night shift nursing assistants (NAs) were rough with her when moving her in bed and transitioning from bed, making her arms sore. Action taken regarding allegation was listed as director of nursing (DON) talking to NA who agreed to pay special attention to the care of Resident #8 in the future. The grievance form did not include documentation an abuse investigation was initiated, nor did the grievance form include documentation a 24-hour report was submitted to the North Carolina health care personnel registry (NCHCPR).</p> <p>Review of facility abuse policy revealed any allegation of abuse made by a resident or staff is to be investigated as abuse and reported within</p>	F 225		

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F 225	<p>Continued From page 9 24 hours to the NCHCPR.</p> <p>Review of facility grievance records between 06/21/13 and 09/05/13 revealed Resident #8 had filed one grievance with the facility regarding staff being rough, which occurred on 06/27/13.</p> <p>Interview with director of nursing (DON) on 09/06/13 at 11:52 AM revealed her expectation that when a resident reports to a nurse that nursing aides have been rough, that nurse is to report it to her as soon as possible. DON goes and talks to the resident who made the allegation but does not directly ask the resident about the allegation. DON stated if the resident uses the same language during the discussion to the DON, a 24-hour notice is submitted to the NCHCPR and an abuse investigation is initiated. DON stated if the resident does not make the same allegation to the DON he made to the nurse, the DON does not submit a 24-hour notice to the NCHCPR or initiate an abuse investigation. DON stated she visited Resident #8 the day she had received the grievance form from Nurse #5 and Resident #8 had referred specifically to one nurse aide needing to be more gentle when working with her. DON said she had not asked resident if the staff had been rough with her or what she meant when she had reported to Nurse #5 that staff had been rough. DON also stated resident had not been assessed by a nurse for possible injuries as a result of the allegation. DON stated because Resident #8 had not used the word "rough" in her description, DON had not proceeded with an abuse investigation or 24-hour notice to the NCHCPR.</p> <p>On 09/06/13 at 4:50 PM the Regional Consultant was interviewed and reported that Administrators</p>	F 225		
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F 225	Continued From page 10 and Directors of Nursing were trained to immediately report any allegation of abuse to the NCHCPR and to initiate a full abuse investigation. The Regional Consultant stated that any time a resident reports that a staff member has been rough, it is considered an allegation of abuse and it is her expectation that it would be reported to NCHCPR, and investigated thoroughly. When reviewing the grievance regarding Resident #8, the regional consultant stated the policy for abuse reporting had not been followed in this incident. On 09/07/13 at 3:35 PM the Administrator was interviewed and reported that his expectation was that any allegation of abuse made by a resident would be reported within 24 hours to NCHCPR and investigated thoroughly. The administrator stated that although the DON would not have directly asked Resident #8 what she meant about nurse aides being rough and causing pain to her arms, the DON had listened to Resident #8's tone of voice after the allegation had been made to Nurse #5 to assess whether the allegation warranted a report to NCHCPR and investigating as abuse.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 226	F226 Residents #35 and #8 continue to reside in the facility and neither resident experienced a negative outcome related to the allegation that the facility failed to follow its own Abuse policy. Each resident was informed of their right to express concerns relating to any allegation of abuse or neglect, and of facility policy regarding identification and prevention	9/30/13	

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F 226	<p>Continued From page 11</p> <p>record review the facility failed to follow their abuse policy for investigating and reporting the cause of a resident's fractured femur for 1 of 1 sampled resident with an injury of unknown origin (Resident #35) and failed to investigate an allegation of staff being rough for 1 of 2 residents' complaints of staff being rough (Resident #8).</p> <p>The findings included:</p> <p>A document titled "Abuse Prevention, Investigation and Reporting" revised 10/04 read in part:</p> <p>Any alleged violations involving mistreatment, neglect or abuse (including injuries of unknown origin) must be reported to the Administrator and/or Director of Nursing IMMEDIATELY. Staff will utilize facility incident reports to record said incidents. The incident report includes, but is not limited to, the name of the resident involved, the date and time the incident occurred, where the incident took place, the names of the persons allegedly committing the act (if known), the type of abuse that is suspected and any other pertinent information. This incident report and the proper reporting to the Administrator and Director of Nursing will initiate a 24 hour initial investigation and decision making process, concluding with a decision to initiate legally mandated reporting procedures for all cases which are determined to truly meet the definition of abuse, neglect or misappropriation of resident's property.</p> <p>Injuries of unknown origin must be evaluated as to the possibility of being resultant of abuse. The investigation includes documentation of evidence to support or refute the possibility of abuse.</p>	F 226	<p>F226 (cont'd) of abuse or neglect. Neither resident has any concerns to report at this time. For other residents with the potential to be affected by this alleged deficient practice the following has been achieved: All Staff were in-serviced to follow facility policy regarding the immediate reporting of all allegations of abuse or neglect, injuries of unknown origin to the Administrator or Director of Nursing. The Administrator and Director of Nursing were in-serviced per facility policy to report all allegations and injuries which are truly of unknown origin (ie: per regulatory definition at F226.) All allegations are investigated by the Director of nursing and or Assistant Director of Nursing and/or Social Worker. The administrator maintains a notebook and reviews all allegations of abuse or neglect. The Administrator is responsible for compliance and maintains a Quality Assurance log of all investigated allegations and reports from this log to the Quality Assurance Committee quarterly. Correction of this alleged deficient practice will be accomplished by September 30, 2013.</p>	
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F 226	<p>Continued From page 12</p> <p>An injury that is more than minor, without explanation and/or does not appear to be common bruising or scrapes incurred in daily living and to a reasonable person could not be considered the result of abuse must be reported and investigated according the procedures indentified in the policy.</p> <p>1. Resident #35 was admitted to the facility on 06/07/12 with diagnoses that included difficulty walking, hypertension, history of cerebrovascular accident, history of fractured lower leg and others. The Minimum Data Set (MDS) dated 02/21/13 specified the resident had moderately impaired cognition and required extensive assistance of two persons with transfers and bed mobility. The MDS also specified the resident did not refuse care and had no behaviors such as being physically abusive towards staff.</p> <p>Further review of the medical record revealed on 05/20/13 the nurse received a physician's order to x-ray the resident's left knee and hip due to continued complaints of pain. The x-ray results revealed the resident had a fractured femur and the physician ordered to send the resident to the hospital.</p> <p>A document titled "History and Physical" dated 05/21/13 specified Resident #35 presented to the Emergency Department for complaints of left leg pain. X-ray results were obtained and revealed the Resident had a fractured left femur. The document also specified Resident #35 was intermittently confused but denied having had an injury or a fall. The Hospital "Discharge Summary" dated 05/22/13 was reviewed and revealed Resident #35's distal fracture of the left</p>	F 226			

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F 226	<p>Continued From page 13</p> <p>femur was not possible to fixate the fracture with hardware (surgery to repair the fracture) due to the resident's brittle bones.</p> <p>On 09/06/13 at 4:10 PM the Director of Nursing (DON) was interviewed and reported that there was no incident report related to Resident #35's fractured femur because "nothing happened." She added that Resident #35 started complaining of pain which was unusual for her and the nurse notified the physician who ordered an x-ray. She explained that the x-ray results did not specify the fracture was trauma-related and she spoke with the physician who told her that given Resident #35's co-morbidities it was very likely for her bones to spontaneously brake. The DON stated she did not consider the injury to be suspicious. She thought she had spoken with staff when she returned to work about the incident but had no documentation of staff statements. The DON explained that given the Resident's diagnoses she felt there was no "unknown" variable that caused the resident to sustain a fractured femur. She added that she did not follow the facility's abuse policy because she did not believe Resident #35's fractured femur was abuse. She stated that Resident #35 returned to the facility after being in the hospital related to the fracture. After the Resident returned to the facility the DON asked the resident if she had fallen or had been mistreated by staff. The DON explained that she felt the resident was "with it enough" to answer the questions and reported that she had not fallen and had not been mistreated by staff.</p> <p>On 09/06/13 at 4:50 PM the Regional Consultant was interviewed and reported that Administrators and Directors of Nursing were trained to immediately report any allegations of abuse and</p>	F 226		
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F 226	<p>Continued From page 14</p> <p>injuries of unknown origin. The Regional Consultant defined injury of unknown origin as suspicious in nature and the resident was unable to report what caused the injury. She stated that she accepted the facility to report within 24 hours to the HCPR to err on the side of caution and then proceed with an investigation to determine the cause of the injury. The Regional Consultant also felt that Resident #35's fractured femur was a result of a pathological fracture but agreed there was no documented investigation to validate the claim.</p> <p>On 09/07/13 at 3:35 PM the Administrator was interviewed and reported that the facility investigated anything that was not able to be explained.</p> <p>2. Resident #8 was admitted to the facility on 06/21/13 with diagnoses that included cerebrovascular accident, abnormality of gait, difficulty in walking and others. The Minimum Data Set (MDS) dated 07/03/13 specified the resident was cognitively intact and required limited assistance with most activities of daily living (ADL) and extensive assist with bed mobility and transitioning from the bed to the wheelchair. The MDS also specified the resident did not refuse care and had no behaviors such as being physically abusive towards staff.</p> <p>Review of facility grievance records revealed on 06/27/13, Resident #8 had reported to Nurse #5 that night shift nursing assistants (NAs) were rough with her when moving her in bed and transitioning from bed, making her arms sore.</p>	F 226		
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F 226	<p>Continued From page 15</p> <p>Action taken regarding allegation was listed as Director of Nursing (DON) talking to Nurse Aide (NA) who agreed to pay special attention to the care of Resident #8 in the future. The grievance form did not include documentation an abuse investigation was initiated, nor did the grievance form include documentation a 24-hour report was submitted to the North Carolina Health Care Personnel Registry (NCHCPR).</p> <p>Review of facility grievance records between 06/21/13 and 09/05/13 revealed Resident #8 had filed one grievance with the facility regarding staff being rough, which occurred on 06/27/13.</p> <p>Interview with Director of Nursing (DON) on 09/06/13 at 11:52 AM revealed the DON had not asked the resident if the staff had been rough with her or what she meant when she had reported to Nurse #5 that staff had been rough. DON stated resident had not been assessed by a nurse for possible injuries as a result of the allegation. DON stated because Resident #8 had not repeated the word "rough" in her description of the incident when talking to the DON, she had not proceeded with any further investigation or 24-hour notice to the NCHCPR.</p> <p>On 09/06/13 at 4:50 PM the Regional Consultant was interviewed and reported that Administrators and Directors of Nursing were trained to immediately report any allegation of abuse to the NCHCPR and to initiate a full abuse investigation. The Regional Consultant stated that any time a resident reports that a staff member has been rough, it is considered an allegation of abuse and it is her expectation that it would be reported to NCHCPR, and investigated thoroughly. When reviewing the grievance regarding Resident #8,</p>	F 226		
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F 226	Continued From page 16 the regional consultant stated the policy for abuse reporting had not been followed in this incident. On 09/07/13 at 3:35 PM the Administrator was interviewed and reported that his expectation was that any allegation of abuse made by a resident would be reported within 24 hours to NCHCPR and investigated thoroughly.	F 226			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide residents with the amount or type of baths/showers that they requested each week for 2 of 3 residents sampled for choices (Residents #117 and #68). The findings included: 1. Resident #117 was admitted to the facility on 01/02/13. Her bathing care plan dated 02/07/13 specified she needed limited assistance with bathing and was to receive a shower every Monday and Thursday. Her most recent Minimum Data Set (MDS) dated 07/11/13 specified her cognition was intact and that she required limited assistance with activities of daily	F 242	F242 This facility follows policy and regulation to honor resident choices. This was achieved for Resident #117 and #4 by interviewing them to ascertain current bathing choices on 9/24/2013. Each stated that their choices were being honored and they required no further considerations regarding bathing. For other residents with the potential to be affected by this alleged deficient practice the following has been achieved: On 9/24/2013, a 100% audit of interviewable residents was conducted regarding bathing preferences and choices. Three questions were asked as follows: • Do you feel that your shower and bathing preferences are honored by staff? • Are the times and days that you get your showers okay with you? • While we cannot promise that we will be able to honor all of your requests, is there	9/30/13	

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F 242	<p>Continued From page 17 living (ADL) such as bathing.</p> <p>On 09/04/13 at 9:30 AM interview with Resident #117 revealed that she received twice weekly showers at the facility but preferred to have a shower every other day. She stated that no one asked her about her bathing frequency. She said that she would feel better if she had showers every other day, but when she asked nursing staff for more showers she was told she could only have two per week.</p> <p>On 09/05/13 at 3:39 PM nurse aide (NA) #3 and nurse aide #4 were interviewed together and reported that when residents were admitted, they were scheduled to have two showers a week, based on the location of their room. NA #4 stated the shower schedule was set by Nurse #3. NA #3 stated nurse aides did not ask residents about their shower preferences, but reminded them of the schedule for their twice weekly showers on occasion. NAs #3 and #4 stated they were aware Resident #117 would like showers more frequently than twice a week, but they provided her with showers on Monday and Thursday.</p> <p>On 09/05/13 at 3:42 PM Nurse #3 was interviewed. Nurse #3 reported that showers were scheduled twice a week for residents and days were chosen based on the hall they lived on and the availability of nurses to complete weekly skin checks (which were completed at the same time as showers). She explained that she did not ask residents or families about shower frequency preferences. Nurse #3 stated she was not aware of Resident #117's shower preferences.</p> <p>On 09/05/13 at 5:04 PM the Admissions Coordinator was interviewed and explained that</p>	F 242	<p>F242 (cont'd) anything special you would like us to consider regarding your bathing.</p> <p>An in-service was provided for all staff regarding bathing choices by the Administrator on 9/27/13. Each resident is notified upon admission of facility protocol of offering full bath (shower protocols) and honors these choices as well as additional requests as much as is possible.</p> <p>The Director Of Nursing audits 3 new admissions weekly for four weeks for the honoring of bathing choices and follow-up (through November 2, 2013.)</p> <p>The facility management team members will continue to conduct "Quality Zone" checks, randomly and routinely assessing the resident's environment and querying them about their bathing preferences as well as 24 hour and 7 day admission surveys which are conducted by the Assistant Director of Nursing with findings reported to the Quality Assurance Committee Quarterly.</p>		

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F 242	<p>Continued From page 18</p> <p>she told admitting residents and families to expect to be offered two showers weekly. The Admissions Coordinator stated that during the admissions process she did not ask residents or families about their shower frequency preferences.</p> <p>On 09/06/13 at 5:17 PM the Director of Nursing (DON) was interviewed and reported that her understanding was that residents and families were asked on admission about their shower preferences.</p> <p>A follow-up interview with the DON on 09/07/13 at 9:38 AM revealed every resident was placed on a 2-shower-a-week schedule unless they told staff they would prefer a different shower schedule. The DON stated she was not aware of Resident #117's preference to receive a shower every other day.</p> <p>On 09/07/13 at 11:05AM Nurse #4 was interviewed and reported she routinely completed the admission assessments for residents and their families and revealed she informed residents and families on admission that two showers per week were scheduled for each resident based on the resident's room location. She did not ask how many showers a week a resident would prefer. Nurse #4 stated she was not aware of Resident #117 would like to have showers every other day.</p> <p>Review of the facility's admission packet did not reveal any information regarding resident preferences for frequency of shower.</p> <p>2. Resident #68 was admitted 01/03/11 with diagnosis including Alzheimer's disease. The</p>	F 242			

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F 242	<p>Continued From page 19</p> <p>most recent Minimum Data Set (MDS) dated 09/01/13 assessed the resident as severely cognitively impaired and unable to understand and make himself understood.</p> <p>Interview with family member of Resident #68 on 09/04/13 at 10:35 AM revealed Resident #68 had preferred to receive a shower every other day before living in the facility, and would prefer to have a shower every other day in the facility. Family member of Resident #68 stated she was told at admission that each resident received two showers per week, based on their room number. Family member of Resident #68 also stated Resident #68 preferred to feel and smell cleaner than he is able to with only receiving 2 showers per week. Family member of Resident #68 stated she had not told any staff about this preference because she was unaware she had any choice regarding the frequency showers could be provided and no staff person had asked her about the resident's preferences.</p> <p>Interview with Nurse Aides (NA) #3 and #4 on 09/05/13 at 3:39 PM revealed when residents are admitted, they are scheduled to have 2 showers per week, based on the location of their room. NA #4 stated the shower schedule is set by Nurse #3. NA #3 stated nurse aides did not ask residents about their shower preferences, but reminded them of the schedule for their twice weekly showers on occasion. NAs #3 and #4 stated they were not aware of Resident #68's shower preferences or those of his family member.</p> <p>Interview with Nurse #3 on 09/05/13 at 3:42 PM revealed showers are scheduled twice a week for residents and days are chosen based on the hall</p>	F 242		
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F 242	<p>Continued From page 20</p> <p>they live on and the availability of nurses to complete weekly skin checks (which are completed at the same time as showers). Nurse #3 said she does not ask residents or families about shower frequency preferences. Nurse #3 stated she was not aware of Resident #68's shower preferences or those of his family member.</p> <p>Interview with the Admissions Coordinator on 09/05/13 at 5:04 PM revealed she told admitting residents and families to expect to be offered 2 showers weekly. The Admissions Coordinator stated that during the admissions process she did not ask residents or families about their shower frequency preferences.</p> <p>Interview with Nurse #1 on 09/06/13 at 11:51 AM revealed although she provided care for Resident #68 for over a year and discussed his care with family member at least weekly, she had never asked family members about Resident #68's shower frequency preferences. Nurse #1 also stated that when residents ask for showers, she reminded them when their 2 showers per week are scheduled.</p> <p>Interview with Director of Nursing (DON) on 09/06/13 at 5:17 PM revealed her understanding that residents and families were asked on admission by the MDS Coordinator about their shower preferences.</p> <p>A follow-up interview with the DON on 09/07/13 at 9:38 AM revealed every resident was placed on a 2-shower-a-week schedule unless they told staff they would prefer a different shower schedule. The DON said the MDS Coordinator documented shower preferences the resident or family</p>	F 242		

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F 242	Continued From page 21 expressed during admission but did not ask residents or families about their preferences. The DON stated she was not aware of Resident #68's shower preferences or those of his family member. Interview with Nurse #4 on 09/07/13 at 11:05 AM, who reported she routinely completed nursing admissions assessments for residents and their families, revealed she informed residents and families at admission that 2 showers per week are scheduled for each resident based on the resident's room location. Nurse #4 stated she was not aware of Resident #68's shower preferences or those of his family member. Review of the facility's admission packet did not reveal any information regarding resident preferences for frequency of shower.	F 242			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to administer insulin to a resident with hyperglycemia (high blood sugars) who was on daily dosages of insulin for 1 of 3 residents on insulin therapy (Resident #175). The findings included: Resident #175 was admitted to the facility on 08/07/13 at 3:00 PM with diagnoses that included	F 281	F281 This facility provides professional services to meet professional standards. This has been achieved for resident #175 by retraining the nurse involved. Further daily review of resident #175 medications on each shift is completed by pulling the "To Do" list which is computer generated and turned into the Director of Nurses, to ensure medication is administered as required and as designated by appropriate staff initials. Resident #175 continues to reside in the facility. Resident #175 receives all insulins as ordered by the MD. For other residents with the potential to be affected by	9/30/13	

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F 281	<p>Continued From page 22</p> <p>type 2 diabetes and kidney disease. The admission Minimum Data Set (MDS) dated 08/14/13 indicated Resident #175 was moderately impaired in cognition for daily decision making and required extensive assistance from staff for activities of daily living.</p> <p>A review of a hospital "Medication Reconciliation Order Sheet Admission/Discharge" document dated 08/05/13 indicated Humalog insulin (a fast acting insulin usually given at meal times) 8 units at breakfast and lunch and Humalog insulin 6 units at dinner.</p> <p>A review of physician's orders dated 08/07/13 indicated Humalog insulin as follows: Humalog 8 units subcutaneously (SQ) before breakfast and lunch Humalog insulin 6 units SQ before dinner Monitor finger stick blood sugars (FSBS)</p> <p>A review of electronic medication administration records (MARs) for 08/07/13 through 09/06/13 indicated a check mark for each medication that had been given.</p> <p>A review of a MAR dated 08/18/13 at 5:00 PM indicated there was no check mark for Humalog insulin 6 units.</p> <p>A review of FSBS results were documented on 08/18/13 at 7:30 AM as 228 milligrams per deciliter (mg/dl) and on 08/18/13 at 12:00 PM as 228 mg/dl.</p> <p>A review of a MAR dated 08/23/13 at 5:00 PM indicated there was no check mark for Humalog insulin 6 units.</p>	F 281	<p>F281(cont'd) this alleged deficient practice the following has been achieved. A 100% audit was completed on 9/11/13 for all current resident medication regimes via charting completed in the electronic health record. All other residents who receive insulin are receiving insulin as ordered. The staff members involved in the alleged deficient practice were in-serviced by the Administrator and Director of Nursing on September 27th, 2013. professional standard of practice with regard to medication administration and documentation thereof; and to check documentation of completed medication administration by pulling "To Do" lists each shift to assure that there are no omissions of documentation for administration of insulin or any other ordered medications. All other nurses were in-serviced by the Administrator and Director of Nursing to pull "To Do" lists generated by the electronic health record to assure that documentation of the administration of all ordered medications are in place. As a monitoring tool, Clean "To Do" ("clean" indicating all scheduled tasks including medications have been</p>	
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F 281	<p>Continued From page 23</p> <p>A review of FSBS results were documented on 08/23/13 at 8:00 AM as 232 mg/dl and on 08/23/13 at 11:50 AM as 186 mg/dl.</p> <p>A review of a MAR dated 08/27/13 at 7:30 AM indicated there was no check mark for Humalog insulin 8 units.</p> <p>A review of FSBS results were documented on 08/27/13 at 11:48 AM as 149 mg/dl and on 08/27/13 at 5:45 PM 198 mg/dl.</p> <p>During an interview on 09/06/13 at 11:58 AM Nurse #7 verified Resident #175's admission orders indicated 8 units of Novolog insulin subcutaneously at breakfast and lunch and 6 units of Novolog insulin subcutaneously at supper. She explained the nurse or a supervisor entered the physician's orders into the computer when a resident was admitted and Resident #175 should be given his insulin as ordered by his physician.</p> <p>During an interview on 09/06/13 at 5:18 PM the Director of Nursing (DON) explained residents' physician orders were faxed to the facility on admission and the nurse who was assigned to the resident was responsible for entering the orders into the computer system. She stated it was her expectation for nurses to give medications to residents as ordered by their physician.</p> <p>During an interview on 09/07/13 at 10:20 AM Nurse #8 explained nurses were expected to give medications to residents as ordered by their physician and there should be a check mark on the electronic medication record that the medication had been given. She further stated</p>	F 281	<p>F281(cont'd) accomplished lists are given to the Director of Nursing on a daily basis. The Director of Nursing reviews the "To Do" lists and is responsible for compliance and reports findings to the Quality Assurance committee quarterly. Corrective actions for the alleged deficient practice will be accomplished by September 30, 2013.</p>	
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F 281	Continued From page 24 there should be a reason documented when a resident did not receive their medication. During a follow up interview on 09/07/13 at 3:20 PM the DON stated it was her expectation that if nurses didn't give medications to a resident there should be documentation as to why the medication wasn't given or some explanation as to why there was not a check mark on the MAR. She verified each medication that was given to residents had a check mark in a box under the date and time the medication was given. She verified she had looked everywhere but could not find any documentation to explain why there were blank spaces on the MAR for insulin for Resident #175 and confirmed doses were missed on 08/18/13 at 5:00 PM; 08/23/13 at 5:00 PM and 08/27/13 at 7:30 AM. She explained there was a place on the MAR where nurses were required to document a reason why the medication was not given. She further explained if staff had typed a note with the reason insulin was not given the note would have appeared on the printed copy of the MAR and verified there was no documentation as to why insulin was not given.	F 281			
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 observations, staff interviews and	F 312	F 312 This facility follows policy to administer routine oral care to all residents. To achieve this for resident #35 the following has been done: Resident #35 dentures were removed by the nurse and cleaned on 9/5/13. Resident # 35 was interviewed by the Regional Nurse on 9/24/13 and resident reports dentures are being removed at night and also cleaned every morning. For other residents with the	9/30/13	

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F 312	<p>Continued From page 25</p> <p>record review the facility failed to provide oral care for 1 of 3 dependant residents reviewed for provide assistance with activities of daily living (Resident #35).</p> <p>The findings included:</p> <p>Resident #35 was admitted to the facility on 06/07/12 with diagnoses that included history of cerebrovascular accident and others. Resident #35's care plan for dentures dated 11/27/12 specified she required extensive assistance with care of her upper dentures and identified that oral care was to be provided daily. The most recent Minimum Data Set (MDS) dated 05/30/13 specified the resident had moderately impaired cognition and required extensive assistance with activities of daily living (ADL) including personal hygiene. The MDS also specified the resident did not refuse care.</p> <p>On 09/03/13 at 3:00 PM Resident #35 was in her room and her mouth was observed and noted to have heavy accumulation of white debris and food particles along the gum line of her upper dentures. She was interviewed and reported that she could not recall the last time her dentures were cleaned and that staff did not assist her daily with care of her dentures.</p> <p>On 09/04/13 at 10:30 AM Resident #35 was in her room and observations of her mouth revealed a similar appearance of heavy white debris and food particles on her upper dentures. The Resident was interviewed and stated that she had not received oral care that morning.</p> <p>On 09/05/13 at 10:00 AM morning care was observed on Resident #35. Nurse aide #1 and</p>	F 312	<p>F312(contd) potential to be affected by the alleged deficient practice the following has been achieved: Direct care givers were in serviced in delivery of oral care to dependent residents by the Director of Nurses. This in-service involved removing of dentures, soaking of dentures, brushing teeth, gums, and tongue. F 312(Cont'd) 100% of residents identified from the resident matrix as dependent for oral care were reviewed for oral care needs. 5 residents dependent for oral care are audited 5 days weekly for 3 months by the wounds care nurse to ensure oral care is provided, teeth clean, fresh mouth, and no debris in mouth . The audits are given to the Director of Nursing for review and follow - up. The Director of Nursing is responsible for monitoring compliance and reports findings to the quality assurance committee quarterly. Corrections for the alleged deficient practice will be accomplished by September 30, 2013.</p>		

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F 312	<p>Continued From page 26</p> <p>nurse aide #2 provided the care that included transferring the resident from the bed to her geri chair (a reclined wheelchair), dressing the resident and attending to personal hygiene (washing her face and grooming). Neither nurse aide #1 nor nurse aide #2 offered or provided oral care to Resident #35. At 10:20 AM nurse aide #1 reported that she had completed Resident #35's morning care. Nurse aide #1 was interviewed and asked about providing oral care for the resident. She replied that Resident #35 wore dentures and second shift was responsible for removing the dentures and soaking them overnight. She added that she routinely cared for Resident #35 and that her dentures were not soaked on a regular basis. The nurse aide reported that she would give the resident a wash cloth to wash her face and added the resident usually took the wash cloth and wiped the lower part of her dentures. Nurse aide #1 stated that it had been a few days since she had assisted the resident with oral care and offered no explanation why she did not perform oral care on the Resident during the morning care. Observations were made of Resident #35's mouth that revealed heavy white debris and food particles accumulated in the upper portion of her dentures. The nurse aides in the room agreed the resident needed her dentures cleaned and nurse aide #1 proceeded to brush Resident #35's dentures.</p> <p>On 09/05/13 at 10:30 AM Resident #35 said her mouth felt better after having her dentures brushed and added she could not remember the last time she had her dentures cleaned by staff.</p> <p>On 09/05/13 at 10:40 AM Nurse #2 was interviewed and reported that she was assigned to Resident #35. She stated that the way she</p>	F 312		
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F 312	Continued From page 27 monitored residents to ensure ADL care was provided was that if the nurse aide did not complete the task in the computer (by checking it off as having completed the care, such as mouth care) then she would get an "alert." The Nurse explained that at the end of the shift she would address any "alerts" to ensure the care had been provided. She stated that Resident #35 was compliant with care and that her dentures should be removed nightly to soak and then cleaned daily on 1st shift by the nurse aides. On 09/05/13 at 10:50 AM the Director of Nursing (DON) was interviewed and reported that staff were trained to provide oral care twice daily for all residents. She explained that in the case of residents with dentures they are encouraged to remove their dentures at night to soak but if their preference was to keep them in then nurse aides should brush their dentures twice daily on 1st and 2nd shift. On 09/05/13 at 12:30 PM nurse aide #1 asked to clarify her statement that it had been a "few days" since she cleaned Resident #35's dentures. She said that it sounded bad and thought she recalled brushing Resident #35's dentures on 09/04/13. Nurse aide #1 offered no explanation why Resident #35's dentures were observed with heavy debris and white matter on 09/04/13 at 10:30 AM after having received morning care if oral care had been provided.	F 312		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	F 323 This facility follows policy and procedure for safely securing residents in the van according to manufacturer's recommendation. This was achieved for resident #70 and	9/30/13

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F 323	<p>Continued From page 28</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and resident interviews, the facility failed to secure 2 of 2 sampled residents (Resident #70 and #5) in the facility van being transported to dialysis. Neither Resident #70's wheelchair nor Resident #5's wheelchairs were attached to the van floor securement system with four point safety restraints. Both residents also had their lap belts secured across their chests instead of their laps.</p> <p>Immediate Jeopardy began on 09/06/13 for Resident #70 and Resident #5. Immediate Jeopardy was removed on 09/07/13 at 5:20 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.</p> <p>The findings included:</p> <p>The facility Maintenance/Safety Driver Director provided a document outlining how to secure wheelchairs in the facility van entitled " Ride Safe" and dated 2005. The document read in part:</p> <p>1. It is important to use a complete wheelchair tie</p>	F 323	<p># 5 were properly and safely secured and restrained per manufacture's recommendation prior to transport to dialysis using 4 point restraints. Neither resident experienced a negative outcome. Resident # 70 has discharged home after achieving goals and resident # 5 continues to safely reside at the facility.</p> <p>For other residents with the same potential to be affected by this alleged deficient practice, the following has been achieved.</p> <p>Van transporter #1 is no longer driving the facility van. The maintenance supervisor was retrained by the administrator for properly and safely securing residents in the van according to manufacturer's recommendations and return demonstration. Van driver #2 was retrained by the maintenance supervisor during the survey with skills check off completed and return demonstration.</p> <p>Each van driver has annual skills check off completed and documented with return demonstration.</p> <p>All transportation by the facility van was suspended until 9/11/13 until each driver was retrained and demonstrated safe transport skills.</p>		

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F 323	<p>Continued From page 29</p> <p>down and occupant restraint system to secure the wheelchair and provide the wheelchair occupant with a properly designed and tested seatbelt system. The most common type of wheelchair tie down uses four straps to secure the wheelchair to the vehicle.</p> <p>2. When securing a wheelchair, attach the four tie down straps to the securement points provided on the wheelchair. It is best to attach the tie down straps to welded junctions of the wheelchair frame or to other structural areas where the frame is fastened together with hardened steel bolts indicated by six raised lines or bumps on the bolt head. Do not attach tie downs to adjustable, moving, or removable parts of the wheelchair such as armrests, footrests, and wheels.</p> <p>3. In addition to securing the wheelchair, it is important to provide effective restraint for the wheelchair user with a crash-tested lap and shoulder belt. The lap belt should be placed low across the front of the pelvis near the upper thighs, not high over the abdomen. The lap belt should be angled between 45 and 75 degrees to the horizontal when viewed from the side.</p> <p>Resident #70 was admitted to the facility on 08/08/13 with diagnoses including kidney disease, renal dialysis, and left sided hemiplegia (paralysis of the left side).</p> <p>The admission Minimum Data Set (MDS) dated 08/08/13 coded Resident #70 as being understood, having clear speech, understanding, and requiring limited assistance with most activities of daily living (ADL). The MDS noted Resident #70 had no memory impairments and had no difficulty with decision making.</p>	F 323	<p>Alternate vendors supplied all resident transportation until 9/11/13.</p> <p>The administrator or maintenance supervisor performs daily audits Monday through Friday to ensure residents are secured according to manufacturer's recommendations. Then unannounced audits will be done twice weekly indefinitely by the Administrator or Maintenance Supervisor. The Administrator is responsible for compliance and reports findings and concerns to the Quality Assurance Committee quarterly.</p>	
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F 323	<p>Continued From page 30</p> <p>Resident #5 was admitted to the facility on 04/09/13 with diagnoses including kidney disease, and renal dialysis.</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 07/23/13 coded Resident #5 as being understood, having clear speech, understanding, and requiring one-person physical assistance with most activities of daily living (ADL).</p> <p>On 09/05/13 at 4:00 PM, Resident #70 was interviewed. She stated Van Transporter #1 rarely secured her wheelchair to the van when going to the dialysis center. She stated by the time she would arrive to dialysis and/or back to the facility her wheelchair would be turned around in a 45 degree turn facing the side door of the van and not the way she was initially put into the van facing forward. She stated she feared she would fall out of the van door. She stated her wheelchair would be locked and she would always be secured with the lap belt but she never felt as secured as she did with other van transporters. She further stated when she was put in the van by other van transporters her wheelchair would not move at all.</p> <p>On 09/06/13 at 7:25 AM, Resident #70 and Resident #5 were observed being placed in the van by Van Transporter (VT) #1. VT #1 was observed to get into the driver ' s seat, close the driver ' s door, start the van, and shift the van into drive in preparation to pull away from the front of the facility. Before the van was able to move, Surveyor #2 approached the driver ' s side window and asked VT #1 if Surveyors #1 and #2 could enter the van to speak with the residents.</p>	F 323		
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F 323	<p>Continued From page 31</p> <p>VT #1 was observed to shift the van into park and open the side door for the surveyors to enter the van. Surveyor #1 and Surveyor #2 entered the van, walked down the van aisle to the back of the van where the two residents were sitting in their wheelchairs. Observations revealed the wheels were locked on both wheelchairs, and lap belts were placed across the chests of both residents instead of across their laps. The 4 point tie down restraints was observed lying in the floor of the van, unsecured to either resident ' s wheelchairs. VT #1 got out of the driver seat and came to the back of van. VT #1 stated she always pulled forward to allow room for possible visitors and/or Emergency Medical Staff (EMS) vehicles before she would secure the residents' wheelchairs. Residents were questioned at that time as to whether wheelchairs moved during transport and Resident #70 stated " Yes, sometimes " and pointed with her left hand index finger toward the right side of van where residents are loaded onto the van by the vans lift. Resident #5 nodded her head up & down in agreement with Resident #70 ' s statement. VT #1 then proceeded to apply the floor securement system restraints to the front and back of both wheelchairs.</p> <p>On 09/06/13 at 8:00 AM, VT #1 was interviewed. She stated she had been driving the facility ' s van approximately 2 years. She stated her training included watching a video, a class, performing hands on demonstration, a return demonstration, and that she received annual in-service training/review performed by the Maintenance Director. She stated she had not had the in-service/training this year but did have the in-service/training last year. She stated she had demonstrated proper securing of residents ' wheelchairs using the 4 point tie down restraints</p>	F 323		
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F 323	<p>Continued From page 32</p> <p>to the frame of the wheelchairs along with properly using the safety seatbelt in addition to locking residents ' wheelchairs during the annual training. She stated there would be minimal movement of the wheelchair and stated that a resident ' s body would have minimal movement when the van brakes were applied if a resident were properly secured. She offered no explanation as to why Resident #70 had reported her wheelchair was able to move during transportation. VT #1 admitted she would often load the residents onto the van unsecured, proceed to move the van forward approximately 30 feet, just in case visitors and/or EMS vehicles would come to the facility. She stated she would then finish securing the residents. She stated this was not part of her training; this was something that she did on her own. VT #1 also stated the lap belt should be fastened across the lap.</p> <p>On 09/06/13 at 1:00 PM, Resident #70 was interviewed. She stated that VT #1 would not drive fast but when going around corners her wheelchair would always move, she would yell out, " whoa " her wheelchair would turn to the side on a 45 degree angle, and she would not be facing forward. She stated while being transported by the facility contracted transport company, from dialysis to the facility, her wheelchair never moved. Resident #70 ' s family member was present during this interview and stated the resident had voiced concern to her numerous times related to her wheelchair turning to the side at a 45 degree angle, and not facing forward during transport to dialysis and/or to facility.</p> <p>On 09/06/13 at 1:10 PM, Resident #5 was interviewed. She stated even though her wheelchair is often not fastened to the straps</p>	F 323		
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F 323	<p>Continued From page 33</p> <p>from the floor, her wheelchair doesn ' t move much during transport to appointments, but she observed Resident #70 ' s wheelchair frequently move several inches to either side and its position changed from facing forward to facing the right side of the van. Resident #5 said the first time she noticed VT #1 not fastening the floor straps was about a month ago.</p> <p>On 09/07/13 at 10:54 AM, Maintenance/Driver Safety Director was interviewed. He stated he went through a training called " Special Needs " and received his certification in driver safety. He stated he trained all facility van transporters using the " Ride Safe " document which outlined the proper use of the four point restraint floor securement system and proper use of the lap belt. The facility van transporters were trained as follows: place residents on the lift, place the residents in the van, lock the residents ' wheelchairs, secure the 4 point tie down restraints to the wheelchairs using right front restraint first, left front restraint next, right back restraint, then left back restraint; after 4 point tie down restraints are secured, place the safety seatbelt around the residents lap from the hip area up to belly button area, depending on the size of the resident, not on the chest. He stated the resident had to be completely secured before moving the van at all. He stated he expected all van transporters to follow this procedure. He further stated the van transporter training should be completed on an annual basis with each van transporter and/or as he received updates related to driving safety. He verified VT #1 received her annual in-service/training 06/2012 but had not had the annual renewal training as of 09/07/13.</p> <p>On 09/07/13 at 2:35 PM, VT #2 was interviewed by telephone. She stated she had the</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>in-service/training on 09/06/13 and the van transporters have the in-service/training annually given by the Maintenance/Driver Safety Director. She stated during the training she had to demonstrate putting residents on the lift, placing the residents in the van, locking the residents wheelchairs, securing the 4 point tie down restraints, right front restraint first, left front restraint next, right back restraint, then left back restraint, after 4 point tie down restraints are secured, then place the safety seatbelt around the residents lap; from hip area up to belly button area, depending on the size of the resident. She stated the residents had to be completely secured before moving the van.</p> <p>The Administrator was informed of Immediate Jeopardy on 09/06/13 at 10:35 AM for Resident #70 and Resident #5.</p> <p>A Credible Allegation of Compliance was accepted on 09/07/13 at 8:43 AM as follows:</p> <p>Credible Allegation of Compliance: Supervision to Prevent Accidents</p> <p>Resident #70 admitted to the facility on 7/15/2013 with diagnosis that included: Stage IV Kidney Disease, Renal Dialysis, Resident #70 uses a gait belt and staff assistance to transfer and is transported via facility van to dialysis three days per week.</p> <p>Resident #5 admitted to the facility 10/08/12 with diagnosis that included: Renal Dialysis, End Stage Renal Disease, Resident #5 requires a total lift for transfers and is transported via facility van to dialysis three times per week.</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>On 09/06/13, Transport Aide #1 was preparing to transport Resident #70 and Resident #5 to their dialysis appointment in the facility ' s van. Transport Aide #1 failed to secure Resident #70 and Resident #5 wheel chairs to the van with four point safety restraints as specified by the manufacturer and was observed by state surveyors to put the van in drive gear to transport the resident to their appointment. Transport Aide #1 was stopped by the state surveyors and transport aide confirmed that both residents were not properly secured for transport. Transport Aide #1 was observed to properly secure both of the resident ' s wheel chairs to the van using four point safety restraints and then proceed to transport Resident #70 and Resident #5 to the dialysis clinic. The residents were not injured in route. The state surveyors informed the facility's administrator of the incident. The administrator arranged for Resident #70 and Resident #5 to be returned to the facility by a contract transport agency. Transport Aide #1, who failed to properly secure the wheel chairs of Resident #70 and Resident #5 on 09/06/13, was immediately suspended upon return to the facility by the administrator. When Resident # 70 and Resident #5 were returned to the facility they were assessed by the Director of Nursing for signs and symptoms of injuries and no injuries were noted.</p> <p>The administrator received certificate of completion for Transporting Passengers with Special Needs February 13, 2008. On 09/06/13 the maintenance supervisor was reeducated by the administrator on how to properly secure wheel chair bound residents to the van for safe transport which included return demonstration.</p> <p>The facility has two transport aides currently</p>	F 323		
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F 323	<p>Continued From page 36</p> <p>employed, other than transport aide #1. On 09/06/13 both of the transport aides were reeducated by the Administrator and Maintenance Supervisor on how to properly secure wheel chair bound residents to the van for safe transport which included a skills checklist with return demonstration. This training included: return demonstration proper lift techniques-boarding and leaving the vehicle, watching heads, hand. Securing wheel chair including wheel chair tie-downs, proper angles and points on the chair, need for additional belts, securing seated passengers, seat belts.</p> <p>If Transport Aide #1 is reinstated by the facility as a transport aide she will be reeducated by the maintenance supervisor on how to properly secure wheel chair bound residents to the van for safe transport before being allowed to return to work including skills checklist and return demonstration.</p> <p>Transport Aides will be required to complete an annual skills checklist with return demonstration which will be provided by the maintenance supervisor to ensure the following: proper wheel chair lift techniques including boarding and exiting the vehicle, securing wheel chair including wheel chair tie-downs, proper angles and points on the chair, need for additional belts, in all aspects of securing seated passengers.</p> <p>All newly hired transport aides are educated and trained by the Maintenance Supervisor or Administrator for skills check off, return demonstration of proper wheel chair lift techniques including boarding and exiting the vehicle, securing wheel chair including wheel chair tie-downs, proper angles and points on the</p>	F 323		
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F 323	<p>Continued From page 37</p> <p>chair, need for additional belts, in all aspects of securing seated passengers.</p> <p>The facility van will not be utilized for resident transport until transport aides have been reeducated on how to properly secure wheel chair residents during transport in accordance with facility policy. Review of facility appointment calendar revealed 7 residents with outside appointments through Tuesday, September 10, 2013. The facility will utilize a contract transport agency for resident transportation to appointments scheduled outside the facility until Wednesday, September 11, 2013. Beginning 09/11/13 the facility van will be utilized for resident transportation.</p> <p>Alternate transport arrangements were made for residents #70 and #5 to return to facility from their respective appointments. Transportation was arranged to the facility with a contract transport agency who returned both residents to the facility on 9/6/13. Both dialysis residents will be transported by a contract transport agency to dialysis on Monday, September 9, 2013.</p> <p>On Wednesday September 11, 2013 residents will be transported via facility staff for appointments by the maintenance supervisor or the alternate van driver. No van driver will be allowed to transport residents until trained and competency has been determined.</p> <p>To prevent any further occurrence:</p> <ul style="list-style-type: none"> · Van driver #1 has been suspended indefinitely pending investigation. · The maintenance supervisor was observed 	F 323		

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F 323	<p>Continued From page 38</p> <p>by the administrator for compliance, via return demonstration on 9/6/13. The administrator received certificate of completion for Transporting Passengers with Special Needs February 13, 2008.</p> <ul style="list-style-type: none"> · The facility has 2 remaining van drivers, who were both retrained, re-educated, using skills check list, and performed return demonstration for safety during resident transfer using facility van on 9/6/2013. Training included the facility certified trainer (maintenance supervisor). The training included: return demonstration proper lift techniques-boarding and leaving the vehicle, watching heads, hand, etc. Securing wheel chair including wheel chair tie-downs, proper angles and points on the chair, need for additional belts, etc. Securing seated passengers, seat belts. The maintenance supervisor was checked by the Administrator. The other trained driver was checked off by the Maintenance Supervisor. <p>Annual skills check off and training is provided by the maintenance supervisor to ensure the following:</p> <ul style="list-style-type: none"> · Return demonstration proper lift techniques-boarding and leaving the vehicle, watching heads, hands, etc. · Securing wheel chair including wheel chair tie-downs, proper angles and points on the chair, need for additional belts, etc. · Securing seated passengers, seat belts. <p>Immediate Jeopardy was lifted on 09/07/13 at 5:20 PM. The facility provided evidence of</p>	F 323		
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F 323	Continued From page 39 additional in-service training for all transportation staff. Interviews and observations of transportation staff securing wheelchair bound residents in the facility van by the administrator and maintenance director were completed. Interviews of transportation staff revealed each staff had been securing the wheelchairs differently and now they were aware of the proper technique for safe transport.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a compressed oxygen cylinder while being transported and failed to ensure that a compressed oxygen cylinder was stored securely in a resident's room. The findings included: 1. On 09/03/13 at 10:30 AM Nurse #1 was observed exiting the West Wing Medication room carrying a full compressed oxygen cylinder by the	F 328	F 328 The facility follows policy for safe handling of oxygen cylinders and this was achieved for nurse #1 by the following: Nurse #1 was in-serviced on safe handling/carrying and storage of oxygen cylinders. Nurse #1 was instructed to use a transport cart for moving oxygen cylinders by the Director of Nursing on 9/6/2013. This was achieved for others to be affected by this alleged deficient practice by the following: All other nurses were in-serviced for safe handling/carrying and storage of oxygen cylinders and were instructed to use a transport cart for moving oxygen cylinders by the Administrator. To monitor compliance: The Director of Nursing and Assistant Director of Nursing will observe 2 nurses weekly for 8 weeks handling oxygen tanks to monitor for proper transportation and safety. The Director of nurses is	9/30/13	

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F 328	<p>Continued From page 40</p> <p>regulator (a device inserted into the top of the tank). The nurse walked from the West Wing nurses' station down the hall into the middle of the Main Dining Room, approximately 60 feet. She was observed to exchange the empty tank stored on the back of a resident's wheelchair with the full tank. The nurse proceed to carry the empty compressed oxygen cylinder out of the Main Dining Room by holding onto the regulator and walked across the hall to the Central Supply closet, approximately 40 feet. Observations were made of the West Wing medication room that revealed there were no transportation carts (a cart specifically designed to secure oxygen cylinders for transportation) available.</p> <p>On 09/05/13 at 11:10 AM Nurse #1 was interviewed and reported that full compressed oxygen cylinders were stored in the medication rooms and that the empty cylinders were stored in the Central Supply closet. She explained that her procedure for exchanging cylinders was to check residents requiring oxygen on their way to morning activities (usually between 9:30 AM - 10:00 AM) and if their tanks were close to empty she would escort the resident into the medication room to exchange the tank. She explained this was to eliminate the need for transporting oxygen cylinders. She reported that if she needed to transport oxygen cylinder then she was trained to use transportation carts stored in the medication rooms to secure the cylinder. She stated that she was trained never to transport a compressed oxygen tank cylinder without securing it in a cart because of the potential hazard that she could drop the cylinder and cause an explosion.</p> <p>On 09/06/13 at 9:05 AM Nurse #1 was interviewed again about the observations made of</p>	F 328	F328 (cont'd) responsible for compliance and reports findings to Quality assurance committee quarterly. The corrective actions for the alleged deficient practice will be accomplished by September 30, 2013.		

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F 328	Continued From page 41 09/03/13 at 10:30 AM and she stated she could not recall carrying a compressed oxygen cylinder into the Main Dining room. On 09/06/13 at 9:15 AM the Director of Nursing (DON) was interviewed and reported that staff were trained to use cylinder carts to secure compressed oxygen cylinders for transportation. She explained that staff should never carry an oxygen cylinder without having it secured in a cart. She added that Nurse #1 should have never carried a full oxygen cylinder that far without having it secured in a cart. 2. On 09/03/13 at 2:30 PM observations of Room 406 were made that revealed a compressed oxygen cylinder lay across the seat of a wheelchair. The compressed oxygen cylinder was not secured or fastened to the wheelchair. Nurse #2 was present for the observation and reported that the cylinder should not be stored like that and removed the tank by carrying the tank in her arms down the hall to Central Supply. The cylinder was observed and noted to be close to empty. On 09/06/13 at 9:15 AM the Director of Nursing (DON) was interviewed about the compressed oxygen cylinder lying in a wheelchair. She explained that it was not appropriate to store an oxygen cylinder in that manner and offered no explanation why it was stored that way. She stated that staff were trained to secure the cylinders to the backs of wheelchairs.	F 328			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333	F 333 This facility administers medications per facility policy and to achieve this, the nurse involved was inserviced in administration of medications	9/30/13	

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F 333	<p>Continued From page 42 any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and record reviews the facility failed to identify a resident prior to administering a laxative to 1 of 5 sampled residents reviewed for medications (Resident #70).</p> <p>The findings included:</p> <p>Resident #70 was admitted to the facility on 08/08/13 with diagnoses including kidney disease, renal dialysis, diabetes, and left sided hemiplegia (paralysis of the left side).</p> <p>The admission Minimum Data Set (MDS) dated 08/08/13 coded Resident #70 as being understood, having clear speech, understanding, and requiring limited assistance with most activities of daily living (ADL). The MDS noted Resident #70 had no memory impairments and had no difficulty with decision making.</p> <p>A review of Resident #70's medical record revealed the physician's order dated 07/25/13. The order specified administer Milk of Magnesia (MOM) 30 milliliters (ml) oral suspension prn (as needed); give day 3 if no BM (bowel movement).</p> <p>A review of the monitoring assessment report dated 08/01/13 through 09/06/13 revealed Resident #70 had a bowel movement (BM) everyday starting on 08/12/13 through 09/06/13.</p> <p>A review of the Medication Administration Record</p>	F 333	<p>and the 5 rights of administering medications. Resident # 70 goals were met and resident has safely discharged home on 9/21/13.</p> <p>For others with the potential to be affected by this alleged deficient practice, the following has been achieved: 100% review of resident (prn) medications was reviewed to ensure medications are administered per each resident request and according to physician order. The nurse involved was inserviced by the director of nurses to call each resident by name when addressing resident and explain to resident the medication pending administration prior to giving the medication and the 5 rights for administration of medications. Licensed Nurses were inserviced to call each resident by name when addressing resident and explain to resident the medication pending administration prior to giving the medication and the 5 rights for administration of medications.</p> <ul style="list-style-type: none"> • Right patient • Right dose • Right route • Right time • Right medication <p>This in-service was provided by the Director of nurses.</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 VANHAVEN DRIVE STATESVILLE, NC 28625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	<p>Continued From page 43 (MAR) for 09/01/13 through 09/06/13 revealed Nurse #6 had administered MOM to Resident #70 on 09/04/13 at 4:11 AM.</p> <p>On 09/05/13 at 8:55 AM, Resident #70 was interviewed. She explained Nurse #6 woke her up from a sound sleep, handed her a cup of medication, and asked her to drink the medicine. She indicated she drank the medication and said "What in the world was that?" Resident #70 stated Nurse #6 informed her that the medication was to help her bowels move and was what she had requested. Resident #70 informed the nurse she had not requested any medication. She further indicated to the nurse she had not been having any problems with her bowels and she had bowel movements everyday. The resident further revealed she had loose stools to the point of diarrhea while at dialysis the morning of 09/04/13 and she was much weaker afterward.</p> <p>On 09/06/13 at 7:13 AM, Nurse Assistant #6 was interviewed. She stated that on 09/04/13 around 4:00 AM the resident in the room next to Resident #70's room had requested a medication for constipation. She stated she informed the nurse of this request and the resident's name.</p> <p>On 09/06/13 at 7:37 AM, Nurse #6 was interviewed. She verified she administered MOM to Resident #70. She stated she assessed the resident prior to administering the MOM. She further stated the resident had bowel sounds and her stomach was not distended. She indicated she had checked the medical record to see if Resident #70 had had a recent bowel movement, but did not find documentation of any. She stated she thought the NA had told her it was Resident #70 who had requested the bowel medication.</p>	F 333	<p>To monitor compliance for continued compliance the following will be achieved: The Director of nurses and assistant director of nurse will observe 2 nurses daily Monday through Friday for administration of medications for 8 weeks. The Director of nurses is responsible for compliance and reports findings to the Quality assurance committee quarterly.</p>	

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F 333	Continued From page 44	F 333		
F 431 SS=E	<p>On 09/06/13 at 4:50 PM, the Director of Nursing was interviewed. She stated she expected nurses to identify and assess the resident before administering any medication.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can</p>	F 431	<p>F 431: Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles and include the appropriate accuracy and cautionary instructions and the expiration date when applicable. All improperly labeled and outdated or expired medications were discarded from the facility to address those residents who were affected by the alleged deficient practice as well as those who had the potential to be affected by the alleged deficient practice. As a systemic change to assure the alleged deficient practice does not reoccur, training was conducted by the pharmacy on storage and labeling of medications for licensed nurses. As an additional systemic change to assure that the alleged deficient practice does not reoccur, audits of stored medications by licensed nurses were implemented at shift change with initials upon completion by both oncoming and outgoing nurses kept on a log sheet in the narcotics books for each nurse assignment. The DON and ADON will monitor daily</p>	9/30/13

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F 431	<p>Continued From page 45 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to label unit dose medications in 2 of 2 medication storage room refrigerators and failed to remove expired medication from 1 of 5 medication carts.</p> <p>The findings included:</p> <p>A review of the facility ' s policy on Medication Storage revealed the following statement: " No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed. "A review of the manufacturer ' s instructions for Tuberculin Aplisol vials indicated vials in use for more than 30 days should be discarded and Lantus Insulin vials in use for more than 28 days should be discarded."</p> <p>An observation on 09/05/13 at 12:24 PM of the East Wing medication storage room refrigerator revealed a Tuberculin Aplisol 1 milliliter (ml) vial did not have a label indicating when it was opened.</p> <p>An observation on 09/05/13 at 12:47 PM of the West Wing medication storage room refrigerator revealed 3 liquid multi-use bottles of an antibiotic; Vancomycin, did not have labels indicating when the bottles had been opened. In addition, West Wing medication storage refrigerator contained 1 liquid multi-use bottle of an antibiotic; Ceftin did not have a label indicating when it was opened.</p>	F 431	<p>for compliance five days per week for one month (through November 2, 2013) after which time logs will be presented to the Quality Assurance and Performance Improvement Committee Quarterly. Corrective action is accomplished by September 30, 2013.</p>	
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F 431	<p>Continued From page 46</p> <p>An observation on 09/05/13 at 3:00 PM of the 200 Hall medication cart revealed Lantus Insulin multi-use vial with a label which indicated it was opened on 08/01/13. Approximately 0.5 ml of insulin was remaining in the vial.</p> <p>An interview on 09/05/13 at 12:30 PM with Nurse #2 regarding the Tuberculin Aplisol revealed the medication was good for 30 days from the date it was opened. Nurse #2 stated the medication should be discarded when found in the refrigerator and was not labeled with an open date. She further stated when a nurse opened a medication they were responsible for checking the expiration date on the medication and for writing an opened date on the medication immediately.</p> <p>An interview on 09/05/13 at 12:55 PM with Nurse #9 regarding liquid multi-use bottles of antibiotic medications should be labeled with an open date written on the bottles. Nurse #9 searched the 4 bottles of antibiotics and confirmed there was not an open date labeled.</p> <p>An interview on 09/05/13 at 3:08 PM with Nurse #10 revealed the Lantus Insulin multi-use vial should not have been on the medication cart with expiration greater than 28 days from the labeled date the medication would have been opened.</p> <p>An interview on 09/05/13 at 4:10 PM with the Director of Nursing (DON) stated her expectation was the floor nurse should have removed the expired medications from the med cart and discarded in the sharps container. She further stated she expected the vials and/or bottles in the medication storage room refrigerators to be</p>	F 431		
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F 431	Continued From page 47 labeled with the date opened immediately.	F 431		
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